80-5303

Supreme Court, U. S.
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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

No. 80-

ANTONIA BELTRAN
~~ROSSYE DAWSON~~, individually and on behalf of all others similarly situated,

Petitioner,

v.

BEVERLEE A. MYERS, individually and in her official capacity as Director of the California State Department of Health; and ELISABETH LYMAN individually and in her official capacity as Deputy Director of the State Department of Health,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the application by California of a "transfer of assets" rule to its medically needy aged, blind, and disabled applicants for, and recipients of, Medicaid, resulting in the denial of assistance to individuals otherwise eligible, contradicts the applicable portions of the Social Security Act and thus violates the Supremacy Clause.

2. Whether the application by California of a "transfer of assets" rule to its medically needy aged, blind, and disabled applicants for, and recipients of, Medicaid, resulting in the denial of assistance to individuals otherwise eligible, violates the due process and equal protection clauses of the Fourteenth Amendment.

LIST OF PARTIES

Petitioner: Antonia Beltran*

Respondents: Beverlee A. Myers and Elisabeth Lyman

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* Rossye Dawson, whose name has remained on the papers throughout this litigation, died while this case was before the district court. Enosinsio Manahan, another named plaintiff, died while the case was before the Court of Appeals. Antonia Beltran is the remaining named plaintiff.

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OPINIONS BELOW

The opinion of the Court of Appeals, as yet unreported, appears as Appendix A. The district court's unreported Findings of Fact and Conclusions of Law of May 10, 1979, with the summary judgment order, are attached as Appendix B.

JURISDICTION

The Court of Appeals filed its Opinion on May 14, 1980. On July 30, 1980, a timely petition for rehearing and rehearing en banc was denied (Appendix C), with this petition for certiorari filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

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CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

The following provisions are significantly involved in this case, and, because of their length, are cited here, with their pertinent texts set out verbatim in Appendix D:

1. United States Constitution, 14th Amendment, §1 (due process and equal protection clauses)

2. Title 42, United States Code, §§1396a(a)(10)(C); 1396a(a)(17)(B)

3. California Welfare and Institutions Code §14015

4. Title 42, Code of Federal Regulations, §435.401(c)(2)

5. Title 22, California Administrative Code, §§50409, 50411(a)

6. Social Security Administration Claims Manual, §12507(a)

STATEMENT OF THE CASE

1. California participates in the Medical Assistance ("Medicaid") program established by Title XIX of the Social Security Act, 42 U.S.C. §1396, et seq.

> "This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. §1396a(b) .... After a state's plan is approved by the Secretary of [the Department of Health and Human Services], the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. §1396." Dawson v. Myers, No. 79-3246, Slip Op., at 2 (9th Cir., May 14, 1980) (App. A, at 2).

Under the federal formula, California is reimbursed 50% of its costs. 44 Fed.Reg. 10553 (Feb. 21, 1979).

A necessary condition of participation and reimbursement is that the state comply with controlling federal law. E.g., Fabula v. Buck, 598 F.2d 869, 870-871 (4th Cir. 1979).

In theory, the Secretary of the Department of Health and Humand Services ("HHS") can deprive the state of its matching funds, 42 U.S.C. §1396c, but as that is the sole sanction available to the Secretary, she rarely, if ever, takes that action. Instead, the Secretary undertakes a process of informing and warning the state of its non-compliance, an effort intended to avoid the drastic remedy of terminating payments to the state. 45 C.F.R. §201.6; see generally Rosado v. Wyman, 397 U.S. 397, 405 n.8 (1970).

Within the confines of the federal statute and regulations, the states have considerable latitude in structuring their programs. If a state decides to participate, it must provide assistance to the so-called categorically needy, who are those individuals meeting both the categorical definitions of age, blindness, disability, or childhood dependency, and their financial eligibility conditions. Even so, the state has flexibility in defining the eligibility conditions of the categorically needy. It can either use the same eligibility conditions as are applicable to recipients of Supplemental Security Income ("SSI"), the federally-administered and -funded welfare program of cash assistance to the aged, blind and disabled, Title XVI of the Social Security Act, or it can use more restrictive eligibility conditions, but no more restrictive than those validly in effect in the state on January 1, 1972. Compare 42 U.S.C. §1396a(a)(10)(A) with 42 U.S.C. §1396a(f); see Slip Op., at 2 & nn.1,2; (App. A, at 2, 17 nn.1,2); see also, e.g., West v. Cole, 390 F.Supp. 91, 95-99 & nn.5,6 (N.D.Miss. 1975). California, like most states, has explicitly chosen to provide Medicaid pursuant to the SSI eligibility conditions. Slip Op., at i n.2 (App. A, at 17 n.2). It is informally

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known, therefore, as an "SSI state."

A state also has the option of providing Medicaid to the "medically needy", who also must meet the categorical definitions but whose income or resources are above the categorically needy levels. 42 U.S.C. §1396a(a)(10)(C); see, e.g., Beal v. Doe, 432 U.S. 438, 440 & n.1 (1977); Friedman v. Berger, 547 F.2d 724, 726 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977). "The medically needy begin receiving assistance after they have incurred medical expenses which reduce their income (and assets) below a prescribed level." Slip Op., at 3 (App. A, at p.3.) California does include the medically needy in its state plan. Id., at 3 (App. A, at p.3.)

In its Medicaid program, which it calls "Medi-Cal", California has adopted a transfer of assets rule.

> "Basically, this prevents persons from qualifying as medically needy if they have transferred assets for less than fair consideration within two years prior to their application for assistance. The transfer rule applies to applicants in the medically needy group; it has no application at all to the categorically needy." Slip Op., at 3 (App. A, at p.3) (emphasis in original).

The eligibility conditions deny medically needy assistance to individuals with resources valued over $1500, 22 Cal.Admin.C. §50420, but homes and certain other properties are exempt from consideration. 22 Cal.Admin.C. §50418, 50425-50489. But if an asset, whether or not exempt, is transferred for less than fair consideration prior to application, a presumption arises that the transfer was effected in order to obtain Medi-Cal eligibility.[1/] The individual is then denied eligibility for a period of time which reflects the actual value of the transferred asset, the cost of care, and the value received for the asset. 22 Cal.Admin.C. §50411.

1/ Whether this presumption is rebuttable or irrebuttable is one of the issues of this case. See, infra, at 17-18.

California has been told by HHS that the application of any transfer rule to its medically needy, however it is worded, violates federal law. As early as September 29, 1978, respondent Myers was informed by letter that the state could not apply a transfer rule to its medically needy aged, blind, and disabled. California has not altered its regulations, and HHS has continued with its efforts to force compliance with federal law. Amicus Brief of Secretary of HHS, lodged in support of Appellants' Petition for Rehearing.

2. The sole living class representative in this case, Antonia Beltran, is, like Rossye Dawson and Enosinsio Manahan, who have died during the course of this litigation, an elderly, sick individual who requires convalescent care but who has been found ineligible for Medi-Cal as a result of the transfer of assets rule. She is now 88, and will require nursing home care indefinitely. About a year prior to her entry into the home on March 20, 1978, she and her husband grant-deeded some land with two houses on it, one of which they lived in, to their children because of the parents' inability to care for the property. They had been determined eligible for Medi-Cal since May, 1977, but she was terminated effective September, 1978, for reasons which are unclear. She re-applied, but was denied assistance in a decision dated January 8, 1979 because of the February, 1977 transfer of the property. The county computed her period of ineligibility to be 885 months, just under 74 years. The most recent bills from her nursing home indicate that she is in debt to the home for over $20,000.

As the Court of Appeals observed,

> "[b]oth Beltran and Manahan were medically needy and otherwise qualified to receive Medi-Cal benefits. However, both were denied benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. Neither

was able to overcome the presumption of ineligibility resulting from these transfers." Slip Op., at 4 (App. A, at 4).

3. This case was filed in forma pauperis by Rossye Dawson on June 19, 1978. Enosinsio Manahan and Antonia Beltran later intervened; Rossye Dawson died before the case was decided on the merits. The intervenors' complaint, like that of Rossye Dawson, sought declaratory and injunctive relief on their own behalf, and on behalf of similarly situated Californians seeking medically needy coverage, invalidating and enjoining the state's policy of denying or terminating Medi-Cal benefits to those who had allegedly transferred assets for less than fair consideration.

The district court granted plaintiffs' motion for class certification on May 10, 1979. On the same day, the court denied plaintiffs' motion for summary judgment, and granted defendants'. The court found that the plaintiffs would have been eligible for Medi-Cal but for the application of the transfer of assets rule. (App. B, at 27.) In its conclusions of law, the court recognized that it had jurisdiction under 28 U.S.C. §1343(3), (4), and 28 U.S.C. §1331.[2/] (App. B, at 27.)

2/ The Court of Appeals questioned, but did not resolve, whether jurisdiction was proper pursuant to 28 U.S.C. §1343(3) and (4), citing Chapman v. Houston Welfare Rights Organization, 441 U.S. 600 (1979), and Doe v. Klein, 599 F.2d 338 (9th Cir. 1979). Slip Op., at ii n.6 (App. A, at 18 n.6). Since the amount in controversy exceeded $10,000, however, "the district court did clearly have federal question jurisdiction (28 U.S.C. §1331)." Id., at ii n.6 (App. A, at 18n.6)(citations omitted). The Court of Appeals had jurisdiction over the appeal pursuant to 28 U.S.C. §1291. Id., at ii n.6 (App. A, at 18 n.6).

The district court agreed with plaintiffs' basic contention that California had obligated itself to provide Medi-Cal to all SSI recipients and that "a state may not impose conditions of eligibility on the medically needy that are more restrictive than those imposed on the categorically needy, that is, recipients of SSI." Conclusions of Law, ¶¶8, 10 (App. B, at 30). Despite these conclusions, it held that the application of a transfer of assets rule to the medically needy (but not to the categorically needy) was permissible, as the rule was a "collateral restriction" and was therefore a "procedural regulation" not a "substantive eligibility requirement." Id., at ¶¶10-11 (App. B, at 30).

As a member of the class was, on the very date of the decision (May 10, 1979), about to be evicted from her nursing home because the transfer rule had rendered her ineligible, she sought an injunction pending appeal from the district court. That was denied by that court on May 11 after plaintiffs filed their Notice of Appeal, but upon docketing the appeal on that same date, she sought and obtained a temporary injunction from an appellate judge.[3/] The request for an injunction pending appeal for the one class member was later extended for the duration of the appeal, but denied without prejudice for the class. That request was renewed upon oral argument, but was denied by the panel hearing the case. Another class member, however, later faced with imminent eviction, also received an injunction pending appeal which provided Medi-Cal benefits during the pendency of the appeal.

3/ Because the appeal had to be filed and docketed immediately, there was not sufficient time to obtain and file the necessary affidavits for the appeal to proceed in forma pauperis.

The panel's decision of May 14, 1980 affirmed the district court, but on considerably different grounds. First, the court specifically repudiated the district court's characterization of the transfer rule, and recognized that it was a substantive eligibility requirement. Slip Op., at 7 (App. A, at 7). But the decision then ignored the explicit interpretation of HHS by determining that the "comparability" language in the statute, 42 U.S.C. §1396a(a)(10)(C), did not require that the medically needy be treated equally with the categorically needy. Slip Op., at 8, 11-13 (App. A, at 8, 11-13.)

The court also held that there was no violation of the "availability" requirement of 42 U.S.C. §1396a(a)(17), as it held that a state can consider former resources to be available. Id., at 11 (App. A, at 11). The court rejected in a footnote plaintiffs' arguments that the transfer rule presented an eligibility condition not countenanced by the Social Security Act, id., at iii n.8 (App. A, at 19 n.8), and held that due process was not violated as the transfer rule did not utilize an irrebuttable presumption. Id., at 13-14 (App. A, at 13-14.) Finally, the panel concluded that there was a rational basis to treat the medically needy differently than the categorically needy, and thus disposed of the equal protection claim. Id., at 14-16 (App. A, at 14-16).[4/]

In light of the fact that three other appellate courts, one state and two federal, had recently reached the diametrically opposite conclusion on plaintiffs' first argument, and that HHS had specifically corroborated the propriety of that argument,

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4/ Since the court ruled against plaintiffs, it explicitly refused to consider plaintiffs' request for an order detailing the manner in which relief should be provided. Slip Op., at v n.13 (App. A, at 21 n.13).

plaintiffs sought a rehearing. On July 21, 1980, HHS lodged an amicus brief supporting plaintiffs' request for a rehearing and repudiating the panel's conclusion that HHS had not directly spoken on the issue of this case. See Slip Op., at 8-9 (App. A, at 8-9). On July 30, 1980, the request for a rehearing and for a rehearing en banc was denied. The court also refused to permit the filing of the HHS amicus brief. (App. C, at 33.)

REASONS FOR GRANTING THE WRIT

I. THE COURT'S RULING ON PETITIONER'S FIRST CLAIM DIRECTLY CONTRADICTS THE INTERPRETATION OF THE RESPONSIBLE FEDERAL AGENCY AND THREE APPELLATE COURTS, AND NECESSARILY VIOLATES A LONG-STANDING PREMISE OF MEDICAID LAW UPHELD BY EVERY COURT WHICH HAS CONSIDERED THE ISSUE

Petitioner's first argument to the courts below involves a simple two-step analysis. First, the categorically needy aged, blind, and disabled (i.e., SSI recipients) do not and cannot have a transfer of assets rule applied to them in determining Medicaid eligibility. Regardless of whether they have transferred, and regardless of the value of the property and the value received for it, they cannot be deprived of Medicaid eligibility. This is so because the Social Security Administration specifically forbids consideration of asset transfers in determining SSI eligibility, Social Security Administration Claims Manual, §12507(a) (App. D, at 37), and because, in the SSI states, the SSI eligibility conditions must be applied to categorically needy Medicaid applicants. 42 U.S.C. §1396a(a)(10)(A). See Blum v. Caldwell, 100 S.Ct. 1635, 1637 (1980) (Marshall, J.) (denying request for

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stay)[5]; Caldwell v. Blum, 621 F.2d 491, 494 (2d Cir.1980), pet. for cert. pending No. 79-2034, 49 U.S.L.W. 3005 (June 24, 1980); Fabula v. Buck, supra, 598 F.2d, at 874 n.13; Scarpuzza v. Blum, 426 N.Y.S.2d 505, 508 n.8, 73 A.D.2d 237 (2d Dept. 1980).

Secondly, a state is forbidden from applying more restrictive eligibility conditions to the medically needy than to the categorically needy. The statute and regulations require this equal treatment, so that the only permissible distinction between the categorically and medically needy is that the latter may have more liberal income and resource eligibility conditions applied to them. 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.401(c).[6]

The panel's conclusion permitting application of a transfer rule is in direct conflict with two other federal appellate courts, both of which determined that the argument outlined above forbade an SSI state from applying a transfer rule to its medically needy. Caldwell v. Blum, supra; Fabula v. Buck, supra. It also directly contradicts a New York state appellate court which relied on the same reasoning. Scarpuzza

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5/ A second application for a stay of Caldwell -- New York's transfer of assets case -- was made after the decision below came down. It was referred to the entire Court and also denied. 100 S.Ct. 2959 (1980).

6/ Case authority for this proposition is cited in full, infra, at p.13 n.9. The only decision with a contrary conclusion, Fabula v. Solomon, 463 F.Supp. 830 (D.Md.1978), was reversed on this point. Fabula v. Buck, supra, 598 F.2d, at 873.

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v. Blum, supra. And, another federal court, also relying on this same argument, declared that Massachusetts' transfer rule violated federal law. Robinson v. Pratt, No. 79-1278-S (D.Mass., June 24, 1980).7/

In addition, the panel's conclusion contradicts the interpretation and order of the responsible federal agency. HHS has informed state Medicaid directors that the relationship between the categorically and medically needy required that the SSI states not apply transfer rules to the medically needy. See Fabula v. Buck, supra, 598 F.2d, at 873 n.10; Caldwell v. Blum, supra, 621 F.2d, 495; Slip Op., at p.8 (App. A, at p.8); Scarpuzza v. Blum, supra, 426 N.Y.S.2d, at 513 & n.19. Indeed, it directly informed defendant Myers of this noncompliance by letter of September 29, 1978. Moreover, HHS has published this interpretation, again based on the arguments made here by petitioners. Health Care Financing Administration Regional Office Manual, Part 6, Medicaid Guidelines, Transmittal No. 31, §1937, reported at CCH Medicare & Medicaid Guide, ¶30,092. And, HHS attempted to file an amicus brief in the Ninth Circuit supporting petitioners' request for a rehearing in which again it noted the propriety of this argument.

In addition to the deviation from this specific interpretation, the decision below also violates the established interpretation of the Medicaid statute which requires states not to apply more restrictive rules to the medically needy than to the categorically needy. HHS details this statutory requirement by regulation: "The [state] agency must not use requirements for determining eligibility for optional coverage

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7/ That court, however, has refused to enjoin application of the state rule on the grounds that it is solely the obligation of HHS to force a state to comply with federal law.

groups that are -- ... (2) For aged, blind, and disabled individuals, more restrictive than those used under SSI ...." 42 C.F.R. §435.401(c).[8/] In the comments to other regulations, which were also dependent on this policy, the agency explained:

> "[42 U.S.C. §1396a(a)(10)(C)(i)] means that while a state might use more generous maintenance amounts in determining financial eligibility ..., all other SSI eligibility criteria are to be used .... [A]ll aged, blind, and disabled persons applying in states covering all SSI eligibles must have their eligibility determined using all SSI eligibility rules except for -- and only except for -- higher dollar amounts for income and resource eligibility levels." 42 Fed.Reg. 2684 (Jan. 13, 1977).

HHS, though, has not been alone in this interpretation. The courts have unanimously agreed that eligibility conditions can be no more restrictive for the medically needy

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8/ This regulatory requirement was previously codified at 42 C.F.R. §448.2(b)(2) and 45 C.F.R. §248.2(b)(2). See Caldwell v. Blum, supra, 621 F.2d, at 497 n.8.

than for the categorically needy.[9/] Indeed, if there is one interpretation of the federal Medicaid statute on which everyone was in agreement, it was this. The Ninth Circuit's decision explicitly deviates from this established authority by interpreting the statute to permit more restrictive treatment of the medically needy.

Thus, with respect to the propriety of transfer of assets rules in the SSI states, the decision of the court below directly contrasts with the decisions of two other Courts of Appeals and with a state appellate court. It also specifically

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9/ Caldwell v. Blum, supra, 621 F.2d, at 497-498, aff'g CCH Medicare & Medicaid Guide, ¶30,093 (N.D.N.Y.1979); Fabula v. Buck, supra, 598 F.2d, at 873; Greklek v. Toia, 565 F.2d 1259, 1261 (2d Cir. 1977), cert. denied sub nom. Blum v. Toomey, 436 U.S. 962 (1978); Friedman v. Berger, supra, 547 F.2d, at 729; Winter v. Quern, CCH Medicare & Medicaid Guide, ¶30,572, at 10,343 (N.D.Ill.1980), previous opinion in same case on same point (by different judge) sub nom. Winter v. Trainor, CCH Medicare & Medicaid Guide, ¶28,151, at 10,599 (N.D.Ill.1977); Hendrickson v. Noot, CCH Medicare & Medicaid Guide, ¶30,499, at 9920 (D.Minn.1980); Dawson v. Beach, supra, Conclusions of Law ¶10 (App. B, at 30); Aitchison v. Berger, 404 F.Supp. 1137, 1149 (S.D.N.Y.1975), aff'd without opinion 538 F.2d 307 (2d Cir.), cert. denied 429 U.S. 890 (1976); Dominguez v. Milliken, CCH Medicare & Medicaid Guide, ¶26,633 at 9221 (W.D.Mich.1973); Schaak v. Schmidt, 344 F.Supp. 99, 103-104 (E.D.Wis.1971) (3-judge court); Scarpuzza v. Blum, supra, 426 N.Y.S.2d, at 511-512; Wong v. Brian, CCH Medicare & Medicaid Guide ¶26,605, at 9014-9015 (Cal.Ct.App.1972). See also Blum v. Caldwell, supra, 100 S.Ct., at 1637.

repudiates the explicit interpretation of the responsible federal agency, despite the deference which is normally paid to agency interpretation and despite the court's inability to demonstrate that that interpretation is inconsistent with the statute.[10/] In addition, the court below contradicts the numerous other courts, and HHS, which have considered the larger issue of proper treatment of the medically needy.

In rejecting New York's first application for a stay, Justice Marshall observed: "The terms of the Social Security Act support the judgment of the Court of Appeals [for the Second Circuit], and the agency responsible for administering the Act is in complete accord with the decision below." Blum v. Caldwell, supra, 100 S.Ct., at 1638. Given that context, the contrary decision of the Ninth Circuit should be reviewed by this Court.

II. THE DECISION BELOW ALSO DEVIATES FROM THOSE OF COURTS EVALUATING PETITIONER'S OTHER SUPREMACY CLAUSE CONTENTIONS

1. Petitioner also argued that application of the transfer rule has the effect of assuming resources available which are not, in fact, available, in violation of 42 U.S.C. §1396a(a)(17)(B). The court rejected that contention as "an overly rigid and literal interpretation of the term 'available' ...." Slip Op., at 11 (App. A, at 11).

There are, however, numerous cases which have strictly interpreted the availability requirement in subparagraph (B) to mean actual availability, as opposed to

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10/ See, e.g., Udall v. Tallman, 380 U.S. 1, 16 (1965); Caldwell v. Blum, supra, 621 F.2d, at 497; Fabula v. Buck, supra, 598 F.2d, at 873.

presumed availability. See, e.g., Brown v. Stanton, 617 F.2d 1224, 1227-1231 (7th Cir.1980), pet. for cert. pending No. 79-1690, 48 U.S.L.W. 3734 (April 24, 1980); Manfredi v. Maher, 435 F.Supp. 1106 (D.Conn.1977) (noting, in the context of Medicaid "deeming", that Congress intended that states not count income which was not in fact available). And, this Court, in its evaluation of the similar availability rule in the Aid to Families with Dependent Children ("AFDC") program, has repeatedly emphasized that states may not merely presume availability. Van Lare v. Hurley, 421 U.S. 338 (1975); Lewis v. Martin, 397 U.S. 552 (1970); King v. Smith, 392 U.S. 309 (1968).

Moreover, courts have also interpreted the availability requirement to forbid the application of transfer of assets rules: "[B]y denying eligibility for assistance over a period of time during which a transferred asset would otherwise sustain the applicant, were it still available, the rule assumes the availability of unavailable resources, in clear contradiction of the case law doctrine." Buckner v. Maher, 424 F.Supp. 366, 373 (D.Conn.1976), aff'd sum. 434 U.S. 898 (1977); see also Udina v. Walsh, 440 F.Supp. 1151, 1155 (E.D. Mo.1977). Contra, Lerner v. Division of Family Services, 235 N.W.2d 478 (Wis.1975); Rinefierd v. Blum, 412 N.Y.S.2d 526, 66 A.D.2d 351 (4th Dept. 1979).[11/]

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11/ Neither the Rinefierd nor the Lerner court had the issue presented in petitioner's first argument, discussed, supra, at 9-14, before it. The court's reliance below on those cases (Slip Op., at 16 (App. A, at 16)), is thus inappropriate in evaluating that issue. See Fabula v. Buck, supra, 598 F.2d at 873 n.10; Scarpuzza v. Blum, supra, 426 N.Y.S.2d, at 510-511.

2. In addition, the use of a transfer rule violates the requirement that states not employ eligibility conditions which are not countenanced by the Social Security Act and which deprive otherwise eligible individuals of benefits. The court below rejected this argument in a footnote. Slip Op., at iii n.8 (App. A, at 19).

This requirement, though, has been conclusively established and adhered to by this Court:

> "[I]n the absence of congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a state eligibility standard that excludes persons eligible for assistance under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause." Townsend v. Swank, 404 U.S. 282, 286 (1971); see also Carleson v. Remillard, 406 U.S. 598 (1972); King v. Smith, supra.

This analysis has been expressly utilized in evaluating transfers of assets rules: "Nowhere in the Social Security Act or in the HEW regulations is there intimation that the mere transfer of assets within two years prior to or during the recept of assistance is to operate as a lever which thrusts the burden of explanation therefor on the applicant." Owens v. Roberts, 377 F.Supp. 45, 55 (M.D.Fla.1974) (3-judge court); see also Fabula v. Buck, supra, 598 F.2d, at 874; Buckner v. v. Maher, supra, 424 F.Supp., at 373; Udina v. Walsh, supra, 440 F.Supp., at 1156.

The states cannot accept federal funds while depriving individuals of benefits by using eligibility conditions which the Act expressly forbids or for which it makes no provision. The decision below on these points violates explicit judicial authority.

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III. THE NINTH CIRCUIT'S DECISION ALSO CONFLICTS WITH DECISIONS ENFORCING CONSTITUTIONAL GUARANTEES

1. Petitioner also argued that California's transfer rule is an irrebuttable presumption which denies her due process. The court determined, however, that the presumption was rebuttable and that there was no constitutional infirmity in discounting evidence that the transfers were not effected in order to obtain eligibility. Slip Op., at 14 (App. A, at 14).

This Court and others have repeatedly determined that irrebuttable presumptions violate the due process clause of the Fourteenth Amendment. E.g., Vlandis v. Kline, 412 U.S. 441 (1973); U.S. Dept. of Agriculture v. Murry, 413 U.S. 508 (1973); Owens v. Roberts, supra. In that latter case, in which Florida's transfer rule was invalidated, the three-judge court noted that the state "regulation ... arbitrarily and irrationally forecloses from eligibility for welfare assistance those individuals who have transferred an asset worth more than $600.00 for less than its assessed or fair market value without regard whatsoever for the good faith of the individual claimant." 377 F.Supp., at 51. In this instance, though more subtly accomplished, the state is taking the same action.

The California statute irrebuttably presumes that a transfer for less than adequate consideration was effected "with intent to qualify for assistance and such act shall disqualify the owner for further aid ...." Welf. & Inst. Code §14015. The regulation implementing that statute, while nominally rendering the presumption rebuttable, permits the applicant only to use "objective facts", and precludes introducing evidence of "subjective intent", i.e., that the

applicant had other, non-fraudulent reasons for transferring. Moreover, the regulation specifically renders irrelevant two explanations which often represent the reason in fact for the transfer: that the individual sought to avoid probate costs or problems (a common action by elderly people) or that the individual was unaware that Medi-Cal existed. 22 Cal.Admin.C. §50409(b)(2). In short, the presumption is only superficially rebuttable; since the state will not consider the most common innocent reasons which an applicant might have, it effectively renders the presumption irrebuttable.

The California rule effectively prevents most applicants from demonstrating the reasons for their actions, thereby establishing a conclusive presumption. By validating that rule, the court below has created a conflict with the numerous courts which have rejected irrebuttable presumptions.

2. Finally, the Ninth Circuit refused to find the differential treatment of the medically and categorically needy to be an equal protection violation. The court found a rational basis for this distinction in the financial savings to the state. Slip Op., at 15 (App. A, at 15). In that conclusion, however, the court ignored the several decisions, including those of this Court, which have refused to view fiscal concerns as providing a sufficient rationale for discriminatory treatment. See, e.g., Memorial Hospital v. Maricopa County, 415 U.S. 250, 263 (1974); Medora v. Colautti, 602 F.2d 1149, 1153 n.9 (3d Cir. 1979); Silbowitz v. Secretary of H.E.W., 397 F. Supp. 862, 867 (S.D.Fla.1975) aff'd mem. 430 U.S. 924 (1977).

Moreover, the court below also determined that the medically needy and categorically needy were not identically situated, Slip Op., at 15 (App. A, at 15), on the theory that the former had more income and resources than the latter. But

that reasoning ignores the Congressional conclusion that those not receiving cash benefits (i.e., the medically needy) are equally impoverished when their incomes are reduced by medical costs. Indeed, the very premise of the medically needy program was to recognize the equality of poverty which existed between the two groups when medical costs were taken into consideration. See, e.g., Aitchison v. Berger, supra, 404 F.Supp. at 1149 & n.43; Brown v. Beal, 404 F.Supp. 770, 778-779 (E.D. Pa.1975).[12/] Once a state opts to provide for the medically needy, it has accepted equality of treatment between the two groups - except, as HHS recognizes, that the medically needy may have more liberal eligibility rules applied to them. See 42 Fed.Reg. 2684 (Jan. 13, 1977).

The impropriety of differential treatment of the two groups has been repeatedly noted by other courts in the statutory context. Supra, at 13 n.9. It has also been suggested that this discrimination may rise to a constitutional violation. See, e.g., Aitchison v. Berger, supra, 404 F.Supp., at 1149. And the Fourth Circuit has noted, in the same context as this case, that there is no rationale for punishing one group of Medicaid applicants for behavior which does not subject

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12/ The court's confusion on this point is especially glaring in light of its misunderstanding of how Title XIX is structured. In explaining how Congress distinguished between the two groups, the court notes: "It must be remembered that the categorically needy receive benefits regardless of whether a state adopts a medicaid program under Title XIX." Slip Op., at 15 (App. A, 15). That is wrong; there is no such requirement. Participation in the federal Medicaid program is entirely optional. The court has failed to grasp the basics of Title XIX.

the other group of Medicaid applicants to any sanction: "[W]e question how the transfers made by plaintiffs, which would be expressly permitted under SSI guidelines, can be fraudulent acts under the Medicaid program simply because they are performed by the medically needy rather than by an SSI recipient." Fabula v. Buck, supra, 598 F.2d, at 874 (footnote omitted).

If there is any logic in denying medical assistance to individuals who transfer assets for less than valid consideration, that logic is equally applicable to the categorically needy. The rule is therefore both underinclusive and overinclusive; there is no valid explanation for differential treatment of these similarly situated Medicaid applicants.

CONCLUSION

The decision below expressly contradicts numerous decisions of this and other federal and state courts. Support for petitioner's position is overwhelming, and on one argument, petitioner's first, is unanimous. In this circumstance, it is entirely appropriate that a writ of certiorari issue to review the decision of the Ninth Circuit.

Respectfully submitted,

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DATED: August 25, 1980.

By _____
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For Publication

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

MAY 14 1980

ROSSYE DAWSON, individually and on behalf of all others similarly situated,	
Plaintiff-appellant,	No. 79-3246
vs.	OPINION
BEVERLEE A. MYERS,* et al.,	D.C. No. C 78-2350 MML
Defendants-Appellees.	

On Appeal from the United States District Court
for the Central District of California
The Honorable Malcolm M. Lucas, Presiding

Before: WRIGHT and ANDERSON, Circuit Judges, and SOLOMON,** District Judge.

J. BLAINE ANDERSON, Circuit Judge:

This is a class action challenging the State of California's transfer of assets rule which was relied upon to deny Medi-Cal benefits to members of the class. In short, this rule denies Medi-Cal benefits to any individual who has transferred assets so as to qualify under the financial eligibility requirements for Medi-Cal. The class members argue that the transfer rule conflicts with the federal Medicaid statutes and regulations, and they also challenge the rule's constitutionality based on due process and equal protection grounds. The court below rejected all of these arguments and upheld the transfer rule. We believe that the district court reached the correct result and affirm.

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*Beverlee A. Myers, the Director of the California State Department of Health Services, is the successor to Edwin W. Beach, the originally named defendant. Since Myers succeeded Beach prior to when this appeal was taken, we make the substitution under Fed. R. Civ. P. 25(d)(1) rather than Fed. R. App. P. 43(c)(1).

**The Honorable Gus J. Solomon, Senior United States District Judge for the District of Oregon, sitting by designation.

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I. BACKGROUND

A. Medicaid

Title XIX of the Social Security Act established the Medicaid program. 42 U.S.C. § 1396 et seq. This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. § 1396(b). Despite the extensive federal standards (42 U.S.C. § 1396a), the individual states are given wide discretion in the administration of their local programs. Norman v. St. Clair, 610 F.2d 1228, 1230 (5th Cir. 1980). After a state's plan is approved by the Secretary of Health, Education and Welfare, the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. § 1396.

A state which has chosen to adopt a Medicaid program has the option of deciding whether it should provide benefits to only one or to both of the statutorily-defined groups of needy persons. States participating in the program must provide assistance to the group which is referred to as the categorically needy.[1/] 42 U.S.C. § 1396a(10)(A). Generally, in order to be considered categorically needy, an individual must be receiving financial assistance, or be financially eligible for such assistance, under Title IV-A of the Social Security Act (Aid to Families with Dependent Children, referred to as AFDC) or Title XVI of the Social Security Act (Supplemental Security Income for the Aged, Blind, and Disabled, referred to as SSI).[2/]

When they establish their Medicaid program, the

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states have the option of also providing benefits to the group which is referred to as the medically needy. This group covers individuals who would qualify for AFDC or SSI except that they have sufficient income and resources to cover the essentials aside from their medical costs.[3/] The medically needy begin receiving assistance after they have incurred medical expenses which reduce their income (and assets) below a prescribed level. Thus, the chief distinction between the two groups is that the categorically needy have lower incomes and less resources than the medically needy.

B. Medi-Cal

California, through its Medi-Cal program, has voluntarily chosen to participate in the Medicaid program. In addition, California voluntarily chose to cover the medically needy as well as the categorically needy. California has adopted a comprehensive statutory and regulatory scheme to implement its Medi-Cal program.

As part of its plan, the California legislature adopted what is called a transfer of assets rule. Cal. (Welf. & Inst.) Code § 14015.[4/] Basically, this prevents persons from qualifying as medically needy if they have transferred assets for less than fair consideration within two years prior to their application for assistance. The transfer rule only applies to applicants in the medically needy group; it has no application at all to the categorically needy.

California has promulgated regulations which, among other things, establish eligibility requirements for the medically needy and implement the transfer rule.[5/] Under these regulations, an individual is eligible as medically needy only if his or her assets are valued at $1500 or less.

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22 Cal. Admin. Code § 50420. An individual's home, income-producing real property, and certain other assets are not counted toward the $1500 limitation. 22 Cal. Admin. Code §§ 50418, 50425-50489. Although this property is exempt insofar as determining eligibility, it remains potentially subject to California's recovery procedures. That is, after the individual dies, California is entitled to recover the cost of medical assistance it provided to the individual from the assets (including both exempt and nonexempt property) which are left in the individual's estate.

Under the regulations which implement the transfer rule, any transfer of assets (including exempt property) for less than adequate consideration creates a rebuttable presumption that the transfer was made for the purpose of establishing eligibility. Unless the applicant rebuts the presumption, the state can deny benefits on this basis.

C. Facts

Dawson, who originally filed this action, has died. Two other individuals, Beltran and Manahan, intervened. Beltran, who is 87, lives in an extended care facility. Manahan, who is 85, lives in a convalescent home. Both Beltran and Manahan were medically needy and otherwise qualified to receive Medi-Cal benefits. However, both were denied benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. Neither was able to overcome the presumption of ineligibility resulting from these transfers.

In their complaint, Beltran and Manahan (referred to as appellants), on behalf of themselves and others similarly situated, sought declaratory and injunctive relief invalidating and enjoining the California transfer rule. In

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addition, the appellants sought reimbursement for those amounts which they had been forced to pay because of the state's transfer rule. The district court certified a class consisting of all those who had been denied Medi-Cal benefits based on California's transfer rule.

On May 10, 1979, the district court granted California'a motion for summary judgment and denied the cross motion filed by the appellants. The court entered findings of fact and conclusions of law which held that the state's transfer rule did not conflict with the federal statutory and regulatory framework, nor did it amount to a denial of due process or equal protection. The appellants then brought this appeal.[6/]

II. DISCUSSION

The appellants make five distinct arguments against California's transfer rule. They claim that it creates an irrebuttable presumption in violation of the due process clause. Since the rule only applies to the medically needy, they contend that it also violates the equal protection clause. Furthermore, the appellants claim that the transfer rule conflicts with two different sections of the federal statutes (42 U.S.C. §§ 1346a(a)(10)(C), 1396a(a)(17)(B), as well as one section of the federal regulations (42 C.F.R. § 435.401). We address the challenges based on the federal statutes and regulations first because if the appellants' arguments are correct, we would not need to reach the constitutional issues. Dandridge v. Williams, 397 U.S. 471, 475-476, 25 L.Ed.2d 491, 90 S.Ct. 1153 (1970). Moreover, in addressing appellants' arguments, the cardinal principle of statutory construction must be kept in mind, that is, statutes should be construed to avoid constitutional questions. See Swain v. Pressley, 430 U.S. 372, 378 n.11,

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97 S.Ct. 1224, 51 L.Ed.2d 411 (1977)

A. 42 U.S.C. § 1396a(a)(10)(C)

Appellants' primary argument is that the California transfer rule conflicts with 42 U.S.C. § 1396a (a)(10)(C), which requires states providing benefits to the medically needy to cover "all individuals who would, except for income and resources" be eligible for SSI (and therefore come under the categorically needy classification), "and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services."[7/] The appellants attribute the following meaning to § 1396(a)(10)(C): "except for the definitional distinction that the medically needy may have higher income and resource levels, the states must use the same rules for the medically needy as for the categorically needy."

Under the Social Security Act, an SSI applicant whose assets exceed the eligibility levels may dispose of the excess assets in order to become eligible for SSI payments. 42 U.S.C. § 1382b(b). This has been administratively interpreted to permit the transfer of the excess assets for less than adequate consideration or as a gift. Social Security Claims Manual § 12507(a). According to the appellants, since transfer rules cannot be applied to SSI applicants (i.e., the categorically needy), they therefore cannot be applied to the medically needy.

The court below rejected the appellants' reasoning and concluded that the California transfer rule did not conflict with § 1396a(a)(10)(C). The court agreed with the appellants that California could not employ any substantive eligibility requirements on the medically needy which were more restrictive than those used for the categorically

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needy. Nevertheless, the court characterized the transfer rule as a collateral or procedural eligibility requirement which was permissible under the Social Security Act. While we agree with the district court that the California transfer rule does not conflict with § 1396a(a)(10)(C), we do not accept the semantic distinction which was relied upon.

We believe that the California transfer rule is properly characterized as a substantive eligibility requirement. It directly applies to the state's determination of whether an applicant's assets exceed the eligibility requirements.

In considering the appellant's argument, we must first turn to the language of the statute itself. Obviously, the face of this statute says nothing about prohibiting transfer rules such as California's.[8/]

The portion of the statute with which we are concerned may be divided into two parts. The first part provides that the medically needy group includes all who would, except for their income and resources, be eligibile for SSI. The second part provides that the medically needy group includes all who have insufficient income and resources, as determined under comparable standards, to pay for their medical care.

The first part specifically excepts income and resources when it equates SSI eligibility to the medically needy eligibility requirements. And so, while this provision does extend all of the SSI eligibility requirements to the medically needy, it does not do so for those which deal with the applicant's income and resources. Were this not the case, then there would be no distinction between the two groups. There can be no question but that the California

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transfer rule is an eligibility requirement which pertains to the applicant's income and resources. It therefore clearly comes within the exception to the first clause of the statute.

The second part may be read as requiring that the evaluation of the applicant's income and resources be determined by using comparable standards. Since an SSI applicant is apparently specifically allowed to transfer assets in the manner which is prohibited by the California transfer rule, we are faced with an inconsistent standard. Nevertheless, this does not make the California rule necessarily in conflict with this part of the statute. After all, the statute only requires the standards to be comparable, not identical. Comparable only means that there must be enough similar characteristics or qualities to make comparison appropriate. Webster's Third New International Dictionary, G.& C. Merriam Co. (1976). The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the medically needy group (including the transfer rule) are not comparable to those which are used under the SSI program.

In support of their argument, the appellants claim that HEW, the agency charged with administering the Medicaid program, has interpreted § 1396a(a)(10)(C) in the same manner as they would have this court. Apparently, three different HEW Regional Medical Directors have written letters stating that state transfer rules are inconsistent with § 1396a(a) (10)(C) because they impose more restrictive eligibility requirements on the medically needy than on SSI applicants. See Fabula v. Buck, 598 F.2d 869, 873 (4th Cir.

1979). Although this court generally defers to an administrative agency's interpretation of the law which it is charged with administering, we are by no means bound by the agency's interpretation. Pacific Coast Medical Enterprises v. Harris, F.2d , slip op. 2516, 2525-2526 (9th Cir., March 28, 1980); Baker v. United States, 613 F.2d 224, 226-227 (9th Cir. 1980).

In the present case, we not only refuse to follow the letter interpretations, but we also refuse to attach any weight to them. Initially, we are convinced that our interpretation of § 1396a(a)(10)(C) is correct, that is, the California transfer rule does not conflict with the statute. This court's "deference does not extend to agencies' construction which conflict with statutory directives." Pacific Coast, supra, slip op. at 2526. While regional administrators may be writing letters disapproving of state transfer rules, HEW as a whole has approved California's Medi-Cal program (and the transfer rule). By this approval, and by not taking any action against California because of the transfer rule, HEW "has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements." Michael Reese Physicians & Surgeons, S.C. v. Quern, 606 F.2d 732, 735-736 (7th Cir. 1979). Based on the preceding, not only do we believe that the letter rulings should not be followed, but we also believe that HEW's general acceptance of California's Medi-Cal program supports our interpretation.

As further support for their argument under § 1396a(a)(10)(C), the appellants rely upon the subsequent legislative history of the Medicaid program. In 1978, as part of the Medicare-Medicaid Administrative and Reimbursement Reform Act, the Senate Finance Committee proposed an

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amendment to the Medicaid statute which would have specifically required states to adopt transfer rules such as California's. S. Rep. No. 95-1111, 95th Cong., 2d Sess., 24-25 (1978). Apparently, relying upon what we have already concluded was an erroneous agency interpretation of § 1396a(a)(10)(C), the Senate Committee said that the states were not able to adopt transfer rules under present law. Id. We recognize that the pronouncements of legislative committees as to the meaning of previously enacted statutes are often afforded considerable deference. Sioux Tribe of Indians v. United States, 316 U.S. 317, 329-330, 62 S.Ct. 1095, 86 L.Ed. 1501 (1942). Nevertheless, courts are not bound by such pronouncements and it has been suggested that subsequently expressed Congressional views should not be relied upon at all. Mathews v. Weber, 423 U.S. 261, 272 n.7, 96 S.Ct. 549, 46 L.Ed.2d 483 (1976). Since the Senate Committee was apparently relying upon the erroneous administrative interpretation, and because we remain convinced that our interpretation of § 1396a(a)(10)(C) is correct, we choose not to accord any deference to the latter legislative pronouncements.

We conclude that California's transfer rule does not conflict with 42 U.S.C. § 1396a(a)(10)(C).

B. 42 U.S.C. § 1396a(a)(17)(B)

The appellants argue that the California transfer rule violates 42 U.S.C. § 1396a(a)(17)(B).[9/] This section requires states to only consider the income and resources which are "available" to the applicant in determining eligibility. The California transfer rule assumes the availability of assets, which, according to the appellants, are no longer available to the applicant.

The appellants' argument may be correct under what

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we believe is an overly rigid and literal interpretation of the term "available" under § 1396a(a)(17)(B). We refuse to interpret this statute as equating available with present record title. This would be inconsistent with the approach which is taken under the Medicaid program.

Initially, "we do not lose sight of the [Medicaid] statute's strong emphasis upon flexibility in determining eligibility." Norman, supra, 610 F.2d at 1240. In another context the Supreme Court interpreted § 1396a(a)(17) as conferring broad discretion on the states to adopt reasonable standards. Beal v. Doe, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977).[10/] The California transfer rule presumes that an asset remains available to an applicant after the applicant has given it away, or sold it for less than adequate consideration. We find nothing in the plain language of this statute which would prohibit such a rule, nor is there anything in the legislative history which equates "available" as requiring present record title or ownership.

To the extent that the regulations address the definition of "available," they support our interpretation. Under the regulations, a state is allowed to examine an applicant's income and assets for a six-month prospective period in determining eligibility. 42 C.F.R. §§ 435.831(a), 435.845(b). Since a state is authorized to consider future assets, it must follow that it should also be allowed to consider those assets which have been recently disposed of under circumstances which indicate that the purpose was to qualify for public medical assistance.

We hold that California's transfer rule does not conflict with 42 U.S.C. § 1396a(17)(B).

C. 42 C.F.R. § 435.401

Appellants also claim that the California transfer

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rule is inconsistent with 42 C.F.R. § 435.401.[11/] This regulation provides that a state Medicaid agency cannot use requirements for determining eligibility for the medically needy which are "more restrictive" than those used for the categorically needy. Since the California transfer rule is a more restrictive requirement, the appellants reason that it therefore violates § 435.401.

While we agree that the California transfer rule imposes a more restrictive requirement on the medically needy, we do not believe that § 435.401 has any bearing on the validity of financial eligibility requirements such as the transfer rule.

First of all, if we were to give § 435.401 the broad reading attributed to it by the appellants, we would be reading an inconsistency into the federal statutory and regulatory framework. The Medicaid program is designed to provide benefits to two differently situated groups. The medically needy are those individuals who have more available income and resources than the categorically needy. By definition, different financial requirements apply to the medically needy than to the categorically needy. Only when § 435.401 is read as not applying to financial requirements, such as the transfer rule, can it be viewed consistently with the other Medicaid statutes and regulations.

After all, § 435.401 is merely one of five sections under the general heading entitled: "Subpart E - General Eligibility Requirements." There is absolutely no discussion of financial eligibility requirements in any of the other sections of this subpart. Instead, the focus of all of the sections is directed toward much more general concerns, such as eligibility requirements which are based on citizenship, alienage, or state residence. In addition, a thorough reading of the statutes and regulations shows

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that the sections of Subpart E parallel the subsections of 42 U.S.C. § 1396a(b). From this it is apparent that Subpart E (including § 435.401) was designed to carry out the statutory mandate of 42 U.S.C. § 1396a(b) which does not involve financial eligibility requirements. See, e.g., Pacific Coast, supra, slip op. at 2526.[12/] And finally, there are three specific subparts which cover the financial eligibility requirements. Subpart G states the general financial eligibility requirements, Subpart H states the financial eligibility requirements for the categorically needy, and Subpart I states the financial eligibility requirements for the medically needy. These specific and detailed guidelines for financial eligibility requirements must control over the general rule of § 435.401.

We conclude that 42 C.F.R. § 435.401 does not apply to financial eligibility requirements and therefore there is no conflict between it and the California transfer rule.

D. Due Process

In their opening brief, the appellants claim that the transfer rule creates an irrebuttable presumption in violation of the due process clause. In their reply brief, the appellants call it an "effectively" irrebuttable presumption. We disagree with either characterization and find that the transfer rule creates a rebuttable presumption which is permissible under the due process clause.

The California transfer rule obviously does not create an irrebuttable presumption. After all, the regulations expressly provide that the presumption may be overcome by evidence that the applicant had adequate resources for support and medical care at the time of the transfer of property. 22 Cal. Admin. Code § 50409(b)(2). Such a determination can be based on "such things as the applicant's . . . age, health, life expectancy, and ability to understand

[the] extent of [his or her] resources." Id. This would mean that if a person was in good health at the time of the transfer, then the presumption might be rebutted because the person would have no reason to anticipate any large expenditure for medical care and support.

The appellants argue that it is an "effectively" irrebuttable presumption because the applicant is precluded from relying on his or her subjective intent. According to the appellants, this excludes the two most likely explanations for this type of transfer, which are: (1) the applicant was unaware of Medi-Cal benefits, and/or (2) a desire to avoid probate. While the state could have considered these subjective considerations, we cannot say that the failure to do so creates a due process violation. California's objective test for determining how the presumption can be overcome does not create an effectively irrebuttable presumption which might run afoul of the due process clause.

E. Equal Protection

The appellants' final argument is based on equal protection grounds. They claim that there is no rational basis for treating the medically needy any differently from the categorically needy. According to the appellants, the medically needy are in the identical situation as the categorically needy, that is, in need of medical care and without sufficient income or resources to pay for it. Since the "transfer of assets" rule only applies to the medically needy, the appellants argue that it violates the equal protection clause because there is no reasonable basis for the disparate treatment between the two groups.

We fail to see how the application of the transfer of assets rule to the medically needy group gives rise to

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even a colorable constitutional claim under the equal protection clause.

Initially, we note that the two groups are not identically situated. By definition, the categorically needy have less income and resources than the medically needy. Furthermore, Congress has obviously viewed the two groups differently, or, at least, as not being identically situated. Why else would Congress have left the decision to provide benefits to the medically needy entirely up to the individual state? It must be remembered that the categorically needy receive benefits regardless of whether a state adopts a medicaid program under Title XIX. However, the medically needy only become entitled to benefits if a state first adopts a program, and, secondly, if the state elects to include the medically needy group in its benefit program.

In addition, California has a rational basis for its transfer rule. California is confronted with two competing interests, the protection of a limited public treasury, and the provision of benefits to those who are in need. The transfer rule was a reasonable response to these conflicting concerns. Under the rule, benefits are provided to those individuals who, in fact, have a financial need, and benefits are denied to the individuals who have artificially created a need by disposing of assets for less than fair consideration.

We hold that California's transfer rule is rationally related to the legitimate government objectives of protecting the public treasury and discouraging intentional impoverishment so as to qualify under a public assistance program. Any disparate treatment resulting from the application of the rule is sufficiently rational to be upheld

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against appellants' equal protection challenge. See Dandridge, supra, 397 U.S. at 471; Richardson v. Belcher, 404 U.S. 78, 83-84, 92 S.Ct. 254, 30 L.Ed.2d 231 (1972); Sims v. Harris, 607 F.2d 1253 (9th Cir. 1979).

III. CONCLUSION

In upholding the California transfer rule, we recognize that the majority of the courts which have been faced with similar challenges have reached the opposite conclusion. See, e.g., Caldwell v. Blum, F.2d , No. 79-7864 (2d Cir. April 10, 1980); Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979); Udina v. Walsh, 440 F.Supp. 1151 (E.D. Mo. 1977); Buckner v. Maher, 424 F.Supp. 366 (D. Conn. 1976), aff'd 434 U.S. 898, 98 S.Ct. 290, 54 L.Ed.2d 184; Owens v. Roberts, 377 F.Supp. 45 (M.D. Fla. 1974); contra, Rinefierd v. Blum, 412 N.Y.S. 2d 526 (App. Div. 1979); Lerner v. Division of Family Services, 235 N.W. 2d 478 (Wis. 1975). Nevertheless, for the reasons stated in this opinion, we are convinced that our analysis of the question is correct.

AFFIRMED.[13/]

FOOTNOTES

1/ The regulations define this group as follows:

> "Categorically needy" means aged, blind or disabled individuals or families and children who are otherwise eligible for medicaid and who meet the financial eligibility requirements for AFDC, SSI, or an optional State supplement;"

42 C.F.R. § 435.4.

2/ States have the option of using more restrictive criteria than those used under the AFDC or SSI programs. California has not chosen this option and so this opinion does not deal with those provisions of the Medicaid Act which would then come into play.

3/ The regulations define this group as follows:

> "Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for medicaid and whose income and resources are above the limits set under the medicaid State plan;"

42 C.F.R. § 435.4.

4/ The statutory part of the transfer rule provides as follows:

> "The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director, and in no event for less than half of the period that the capital value of the transferred property would have supplied the person's maintenance needs based on his circumstances at the time of his transfer plus the cost of any needed medical care."

Cal. (Welf. & Inst.) Code § 14015.

5/ The transfer rule is implemented, for the most part, through 22 Cal. Admin. Code §§ 50408, 50409. The first section (§ 50408) states the general conditions for when the transfer of property will not result in ineligibility. The rule and the procedure for overcoming the presumption are then stated in § 50409:

"(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet at least one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

"(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

"(1) It shall be presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).

"(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

"(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

"(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption."

6/ The district court concluded that it had jurisdiction under 28 U.S.C. § 1343(3) & (4) (civil rights jurisdiction) and under 28 U.S.C. § 1331 (federal question jurisdiction). It is unclear whether jurisdiction was properly invoked under 28 U.S.C. § 1343. See Chapman v. Houston Welfare Rights Org., 441 U.S. 600, 99 S.Ct. 1905, 60 L.Ed.2d 508 (1979); Doe v. Klein, 599 F.2d 338 (9th Cir. 1979). Nevertheless, the amount in controversy exceeds $10,000 and so the district court did clearly have federal question jurisdiction (28 U.S.C. § 1331). Brown v. Stanton, F.2d No. 79-1459, slip op. 2 n.1 (7th Cir. 1980); see Chapman, supra, 60 L.Ed.2d at 515. Since the appellants filed a timely notice of appeal from the final judgment, this court has jurisdiction to consider the appeal under 28 U.S.C. § 1291.

7/ This statute provides, in part, as follows:

"A state plan for medical assistance must ---provide---

"(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary--

"(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

"(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

* * *"

(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a)(10).

8/ At one point, appellants suggest that states can only use requirements which are explicitly authorized by the federal statute. We were unable to find any provision of the statute which said this. In the absence of some expression by Congress to the contrary, we decline to read such a prohibition into a statute which is, after all, establishing a cooperative federal state program. See, New York Department of Social Services v. Dublino, 413 U.S. 405, 93 S.Ct. 2507, 37 L.Ed.2d 688 (1973) ("It will not be presumed that a federal statute was intended to supersede the exercise of the power of the state unless there is a clear manifestation of an intention to do so." 413 U.S. at 413, quoting Schwartz v. Texas, 344 U.S. 199, 202-203, 73 S.Ct. 232, 97 L.Ed. 231 (1952)).

9/ This statute provides in part as follows:

"A state plan for medical assistance must---

"include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits . . .

* * *"

(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a)(17).

10/ The Supreme Court was considering the extent of medical assistance which the states were required to provide. Beal, supra, 432 U.S. at 444.

11/ This regulation provides as follows:

"(a) A medicaid agency may not impose any eligibility requirement that is prohibited under title XIX of the Act.

"(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and that are consistent with the objectives of title XIX.

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"(c) The agency must not use requirements for determining eligibility for optional coverage groups that are--

"(1) For families and children, more restrictive than those used under the State's AFDC plan; and

"(2) For aged, blind, and disabled individuals, more restrictive than those used under SSI, except for individuals receiving an optional State supplement as specified in § 435.230 or individuals in categories specified by the agency under § 435.121."

(emphasis added to show that portion of the regulation which the appellants rely upon)

42 C.F.R. § 435.401.

12/ In Pacific Coast, supra, this court noted that "[e]xisting regulations must be construed in light of the statutory mandates under which they issue." Slip op. at 2526.

13/ Appellants also ask this court, providing they prevail on this appeal, to grant the full measure of relief requested in their complaint and provide notice to all class members. Because we affirm the district court, it is unnecessary for us to address the propriety of this request.

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CLERK, U. S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ENTERED
MAY 10 1979
CLERK, U. S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
BY DEPUTY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

ROSSYE DAWSON, individually and on behalf of all others similarly situated, Plaintiff, v. EDWARD BEACH, et al., Defendants.	NO. 78-2350 MML(Sx) PROPOSED SUMMARY JUDGMENT
ANTONIA BELTRAN AND ENOSINSIO MANAHAN, Individually and on behalf of all other similarly situated, Intervenor-Plaintiff,	

This cause came on to be heard on motion of the defendants for summary judgment and on cross-motion of the plaintiffs and intervenor plaintiffs for summary judgment, pursuant to Rule 56 of the Federal Rules of Civil Procedure, and the court having considered all papers, and the court having heard the argument of counsel, and due deliberation having been

had thereon, it is

ORDERED, that plaintiffs' cross-motion for summary judgment be and the same hereby is denied, and it is further

ORDERED, that defendants' motion for summary judgment be and the same hereby is granted, and it is further

ORDERED, ADJUDGED AND DECREED that the action be dismissed on its merits, and that EACH SIDE BEAR OWN defendants recover their costs of suit.

DATED: 5/10/79.

MALCOLM M. LUCAS
United States District Judge

FILED

MAY 10 1979

CLERK, U. S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
BY [illegible] DEPUTY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

ROSSYE DAWSON, individually and on behalf of all others similarly situated, Plaintiff, v. EDWARD BEACH, et al., Defendants.	NO. CV-78-2350-MML FINDINGS OF FACT AND CONCLUSIONS OF LAW
ANTONIA BELTRAN and ENOSINSIO MANAHAN, individually and on behalf of all others similarly situated, Intervenor-Plaintiff,	

This cause came on for hearing on defendants' Motion for Summary Judgment and plaintiffs' Cross-Motion for Summary Judgment, and the Court, having considered the memoranda of points and authorities filed by the parties in support of such motions and the documents and exhibits thereto, and the stipulation of the parties, and having heard oral argument by the parties in support of such motions, finds the facts and states the conclusion of law as follows:

FINDINGS OF FACT

1. With respect to Rossye Dawson.

a. On February 18, 1977, an application for Medi-Cal was filed on behalf of Rossye Dawson;

b. The County of Riverside Department of Public Social Services approved the application pending a property verification;

c. On May 17, 1977, the County of Riverside Department of Public Social Services sent a Notice of Action letter to Rossye Dawson determining that she was no longer eligible for Medical-Cal because she had transferred property without adequate consideration in violation of Title 22, California Administrative Code section 50409;

d. Rossye Dawson filed a request for a fair hearing, which was held on September 14, 1977;

e. The hearing officer found that the transfer of property for inadequate consideration was made in May 1977, that Rossye Dawson had failed to overcome the presumption that the transfer was made for the purpose of qualifying for Medi-Cal, and that therefore her claim for Medi-Cal benefits should be denied;

f. The proposed decision of the hearing officer was adopted by the Director of the State Department of Health on February 15, 1978;

g. Rossye Dawson has never sought judicial review of the director's decision by filing a petition for writ of mandate pursuant to section 1094.5 of the California Code of Civil Procedure; and

h. On or about October 30, 1978, counsel for Rossye

Dawson filed a "Certificate of Counsel re Death of Plaintiff." No substitution for the deceased plaintiff has been made.

2. With respect to intervenor Enosinsio Manahan:

a. On April 12, 1978, an application for Medi-Cal was filed on behalf of Mr. Manahan;

b. The Orange County Department of Social Services denied his application on the ground that he had transferred property in order to be eligible for Medi-Cal in violation of, inter alia, Title 22 California Administrative Code section 50409;

c. A fair hearing was requested and held on July 6 and 7, 1978 on the county's denial of Medi-Cal;

d. The hearing officer found that Mr. Manahan had overcome the presumption that the transfer of property was for the purpose of qualifying for Medi-Cal. The hearing officer recommended that he be eligible for Medi-Cal once he met the Medi-Cal property limit spend-down.

e. On January 12, 1978, the Director of the State Department of Health Services reversed the proposed decision of the hearing officer. The director found that Mr. Manahan had not overcome the presumption; and

f. He has not sought judicial review of the director's decision by filing a petition for writ of mandate in the state court pursuant to California Code of Civil Procedure section 1094.5.

3. With respect to intervenor Antonia Beltran:

a. On October 27, 1978, she re-applied for Medi-cal benefits;

b. The Notice of Action dated January 8, 1979 indicated that the denial of Medi-Cal eligibility was based on a transfer of property in 1977.

c. She did not request a fair hearing from the determination of the county, and no fair hearing was held.

4. Except for the application of the transfer of assets rule to these three individuals, they would be eligible for Medi-Cal coverage under the state's medically needy program.

5. Defendant Beverlee A. Myers, successor to Edwin W. Beach, is the Director of the California State Department of Health Services, successor to the State Department of Health.

6. Defendant Elisabeth Lyman, successor to Bruce Yarwood, is the Acting Chief Deputy Director of the Medical Care Services and Medical Care Standards Division of the State Department of Health Services.

7. To the extent that any of the following conclusions of law are deemed findings of fact, the same are incorporated herein by reference.

CONCLUSIONS OF LAW

1. The Court has jurisdiction over this case pursuant to 28 U.S.C. §1343(3), (4), as this is an action authorized by 42 U.S.C. §1383 to redress the deprivation of rights under color of state law. The Court has pendent jurisdiction over any claims not specifically authorized pursuant to 42 U.S.C. §1983. Jurisdiction is also conferred by 28 U.S.C. §1331, as there is more than $10,000.00 in controversy. This case has been certified as a class action.

2. Rossye Dawson lacks capacity to sue as she is deceased and no substitution has been made for her pursuant to Federal Rules of Civil Procedure section 25(a)(1).

3. The federal Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., is a system of cooperative federalism in which the states and other jurisdictions have the option to participate, and to receive partial reimbursement for services provided. If they decide to participate, the states are required to operate their Medicaid Program within the contours of the federal statute and regulations, and to submit a state plan to the Secretary of the Department of Health, Education, and Welfare that comports with controlling federal laws. In order to be eligible for reimbursement, the states which decide to participate must comply with the mandatory requirements established by the Social Security Act as interpreted and implemented by HEW. Townsend v. Swank, 404 U.S. 282, 286 (1971); King v. Smith, 392 U.S. 309, 333 (1968); County of Alameda v. Carleson, 5 Cal.3d 730, 739 (1971); Wong v. Brian, CCH Medicare & Medicaid Guide, [1974] Transfer Binder, ¶26, 605 (Cal.Ct. App. 1972).

4. Once a state decides to participate, it must provide Medicaid benefits to the "categorically needy", who are individuals meeting both the categorical requirements of being aged, blind, or disabled, and also the financial eligibility requirements. 42 U.S.C. §1396a(a)(10)(A); 42 C.F.R. §435.120; see Friedman v. Berger, 547 F.2d 724, 726 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977); Wong v. Brian, supra, ¶26, 605 at 9013.

5. In addition, states have the option of providing Medicaid assistance to the so-called "medically needy" who are individuals meeting the categorical requirements of being aged, blind or disabled, but who have incomes or resources above the financial requirements. 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.300 et seq.; see Friedman v. Berger, supra; Wong v. Brian, supra.

6. California has opted to participate in the Medicaid Program, and has further opted to provide assistance to the medically needy. 22 Cal.Adm. Code §60249(a)(1); Wong v. Brian, supra.

7. The general rule is that recipients of Supplemental Security Income ("SSI"), who are aged, blind, or disabled individuals receiving federal cash benefits, are categorically needy and are therefore automatically eligible for Medicaid. 42 U.S.C. §1396a(a)(10(A). California, as well as other states, has been given the option by Congress of using a different eligibility test for the categorically needy than that they be recipients of SSI. Under this test, a state can use more restrictive financial eligibility conditions than those set out in the SSI program, but no more restrictive than those in effect in the state on January 1, 1972. 42 U.S.C. §1396a(f); 42 C.F.R. §431.121; see Hayes v. Stanton, 512 F.2d 133, 137-138 (7th Cir. 1975); West v. Cole, 390 F.Supp. 91, 95-96 (N.D. Miss. 1975); Gray Panthers v. Secretary, Department of Health, Education and Welfare, 461 F.Supp. 319, 321 (D.D.C. 1978).

. . . . . .

8. In its Medicaid Program, known in this state as Medi-Cal, California has not selected this option, and therefore must provide, and does provide, automatic categorical assistance to all recipients of SSI. Cal.Adm. Code §50227.

9. The federal Medicaid statute requires those states which provide medically needy benefits to include as eligible "all individuals who would, except for income and resources, be eligible to have paid with respect to them Supplemental Security Income benefits. . . . " 42 U.S.C. §1396a(a)(10)(C)(i).

10. A state may not impose conditions of eligibility on the medically needy that are more restrictive than those imposed on the categorically needy, that is, recipients of SSI. 42 C.F.R. §435.401(c). Of course, a state may impose collateral restrictions on the medically needy that are not imposed on the categorically needy. 42 U.S.C. §1396a(a)(17)(A); 45 CFR §233.10(a)(1)(ii)(B).

11. Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 are designed to eliminate fraudulent practices affecting eligibility for benefits. The federal statute is concerned with substantive eligibility requirements only, and does not place any specific restrictions on the state's right to police fraud. Consequently, the transfer of assets rule is a procedural regulation which is not prohibited by 42 USC §1396a(a)(10)(C)(i).

12. Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 do not violate 42 U.S.C. §1396a(a)(17)(B) or 42 CFR §435.845. The purpose of these state law provisions is to deter transfers of assets solely for the purpose of qualification.

To the extent an asset is transferred for the purpose of qualifying for benefits, the asset should be treated as being available for the applicant's use.

13. Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 are not in conflict with any federal law or regulation governing the Medicaid/Medi-Cal program. They do not violate the Supremacy Clause of the United States Constitution

14. Cal. Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409 do not establish an irrebutable presumption that a transfer of assets was made with the intent of gaining eligibility and so do not violate the due process clause of the Fourteenth Amendment to the United States Constitution.

15. A rational distinction between SSI recipients and the medically needy is made in Cal. Welf. & Inst. Code §14015 and 22 Cal. Adm. Code §50409. The state has an interest in assuring that medical assistance benefits are dispersed only to those who are truly in need. Those receiving SSI by definition are in financial need. It is rational for the state to scrutinize transfers of assets by the medically needy to assure that financial eligibility is not improperly manufactured. The Court therefore holds that the equal protection clause of the Fourteenth Amendment has not been violated by Cal.Welf. & Inst. Code §14015 and 22 Cal.Adm. Code §50409.

16. To the extent that any of the foregoing findings of fact are deemed conclusions of law, the same are incorporated herein by reference.

17. The plaintiff's motion for summary judgment is

denied, and the defendants' motion for summary judgment is granted. Judgment shall be entered accordingly.

Dated: May 10, 1979

Malcolm M. Lucas
United States District Judge

FILED

IN THE UNITED STATES COURT OF APPEALS JUL 30 1980

FOR THE NINTH CIRCUIT

RICHARD H. DEAN
CLERK, U.S. COURT OF APPEALS

ROSSYE DAWSON, individually and on behalf of all others similarly situated,

Plaintiff-Appellant,

vs.

BEVERLEE A. MYERS, et al.,

Defendants-Appellees.

No. 79-3246

O R D E R

Before: WRIGHT and ANDERSON, Circuit Judges, and SOLOMON,* District Judge.

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for a rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The motion of the Secretary of Health and Human Services for permission to file an amicus curiae brief is DENIED.

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

*The Honorable Gus J. Solomon, Senior United States District Judge, District of Oregon, sitting by designation.

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1. United States Constitution, 14th Amendment, §1 (due process and equal protection clauses):

> "... nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

2. Title 42, United States Code, §§1396a(a)(10)(C), 1396a(a)(17)(B):

> "A State plan for medical assistance must
>
> (10) provide -
>
> (C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary -
>
> (i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and
>
> (ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope ...."

[and]

> "(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which ... (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or

recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits ...."

3. California Welfare & Institutions Code, §14015:

"The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director, and in no event for less than half of the period that the capital value of the transferred property would have supplied the person's maintenance needs based on his circumstances at the time of his transfer plus the cost of any needed medical care."

4. Title 42, Code of Federal Regulations, 435.401 (c)(2):

"(c) The agency must not use requirements for determining eligibility for optional coverage groups that are -

...(2) For aged, blind and disabled individuals, more restrictive than those used under SSI, except for individuals receiving an optional State supplement as specified in §435.230 or individuals in categories specified by the agency under §435.121."

5. Title 22, California Administrative Code, §§50409, 50411:

"50409. Transfer of Property Which Results in Ineligibility. (a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet at least one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

(1) It shall be presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost.

(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption."

"50411. Period of Ineligibility Due to Transfer of Property. (a) Following a determination of ineligibility due to the transfer of property, there shall be a period of ineligibility. This period shall be the time during which the net market value of the property at the time of transfer, less consideration received, would have supported the applicant or beneficiary and the applicant's or beneficiary's family.

(b) The period of ineligibility shall be computed in the following manner:

(1) Determine the net market value of the property at the time of transfer less any consideration received which is the net value of the property transferred.

(2) Determine the portion of the net value of the property transferred which, if included in the property reserve at the time of transfer, would not have caused such reserve to exceed the property limit that was applicable at that time.

(3) The portion of the net value of the property transferred that would not have fallen within the property limit at the time of transfer is the excess net value of the property transferred and shall be used to determine the period of ineligibility.

(4) The number of months in the period of ineligibility shall be determined by dividing the excess net value of the property transferred by the monthly maintenance need for the applicant or beneficiary and the applicant's or beneficiary's family. The maintenance needs used shall be the maintenance needs in effect during each individual month since the date of the transfer. Income received by the family after the transfer shall not affect this computation.

(5) The period of ineligibility may be further reduced by deducting the actual cost to the applicant or beneficiary of the following:

(A) Medical expenses.
(B) Out-of-home care costs in excess of the maintenance needs.
(C) Major home repairs necessary to put the home into a liveable condition.

(c) The period of ineligibility shall begin the first of the month following the date the transfer which resulted in ineligibility occurred, unless a 10-day notice is required and cannot be given. In that case, the period of ineligibility shall begin the first of the next month.

(d) The period of ineligibility shall end when any of the following situations occur:

(1) The property which was transferred and caused ineligibility is reconveyed to the applicant or beneficiary.
(2) The applicant or beneficiary receives adequate consideration for the property.
(3) Deduction of the amounts specified in (b)(4) and (5) has reduced the excess net market value to zero."

6. Social Security Administration Claims Manual, §12507(a):

"12507. Disposition or transfer of Resources Prior to Filing Application

(a) General

The valid disposal or transfer, as by sale or gift, of a resource prior to the filing of an SSI program application, does not preclude eligibility for payment, even though retention of the resource would have placed an individual's or couple's resources over the applicable limit. This is true with respect to cash and real or personal property and also true though the resource may have been given as a gift or sold for less than its market value to a relative or friend.

In addition, an individual may also reduce his resources, for the purpose of being within the applicable limits, by prepaying debts (such as rent, taxes, installment charges, etc.). (Note: where a renter has prepaid rent, do not count the rental value of the dwelling as unearned income.)

However, such prepayments must be bona fide and irrevocable. If an individual has the legal right to get a prepayment back, those funds available to him are still his resource."

No. 80-5303

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

ANTONIA BELTRAN, individually and on behalf of all others similarly situated,

Petitioner,

v.

BEVERLEE A. MYERS, individually and in her official capacity as Director of the California State Department of Health; and ELISABETH LYMAN, individually and in her official capacity as Deputy Director of the State Department of Health,

Respondents.

MOTION OF PETITIONER FOR SUMMARY REVERSAL AND REMAND IN PART, AND FOR VACATION AND REMAND IN PART DUE TO INTERVENING LEGISLATION

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MOTION OF PETITIONER FOR SUMMARY REVERSAL AND REMAND IN PART, AND FOR VACATION AND REMAND IN PART DUE TO INTERVENING LEGISLATION

After Petitioner's brief was filed, the President signed legislation, Pub.L. 96-611, §5, -- Stat. ---, on December 28, 1980, which has a direct bearing on the issue of this case.[1/] Since the nature of this legislation, and its indisputable purpose as explained in its legislative history, resolve the issue of this case for certain members of the class, Petitioner requests that the Court reverse summarily, pursuant to Rule 23.1, Rules of the Supreme Court. Furthermore, since the new federal statute creates different concerns about the propriety of the California provision after its effective date (July 1, 1981), it is appropriate that the case be remanded for those members of the class who will apply after that date.

I. THE NEW FEDERAL LEGISLATION RESOLVES ANY REMAINING DOUBT THAT EXISTING FEDERAL LAW PRECLUDES CALIFORNIA, AND WILL PRECLUDE IT UNTIL JULY 1, 1981, FROM EMPLOYING ANY MEDICAID TRANSFER OF ASSETS RULE, THEREBY REQUIRING SUMMARY REVERSAL

A. The new law was explicitly intended by Congress to change a perceived "inadequacy" in the existing federal Medicaid statute.

Plaintiffs have argued at all levels of this litigation that California could not apply a transfer of assets rule

---

1/ Since Petitioner is proceeding in forma pauperis, her typewritten brief had to be received in the Clerk's office by December 11, thus precluding her from alluding to Congressional passage of this legislation, H.R. 8406, which occurred on December 13. See 126 Cong.Rec. S16504 et seq. (daily ed., Dec. 13, 1980).

since it represented a more restrictive treatment of the medically needy than of the categorically needy aged, blind, and disabled. Congress has previously recognized this, and has now passed legislation which is specifically intended to permit states to employ a transfer of assets rule against SSI applicants and against Medicaid applicants, including both the categorically and medically needy. Senator Long, who co-sponsored the amendment to H.R. 8406, which allows this, explains succinctly what the present law on this issue is:

> "In recent years a number of States have uncovered an abusive practice in which certain individuals transfer substantial assets to their families or to others in order to bring themselves down to the welfare eligibility level which will qualify them for payments under the supplemental security income (SSI) program and for fully paid medical care under the medicaid program. Unfortunately, the present law is so written as to make this subterfuge possible." 126 Cong.Rec. S16505 (daily ed., Dec. 13, 1980) (emphasis supplied).

While plaintiff disagrees with the Senator's subjective analysis, his conclusion, which is the same as that reached by other Senate and House members and committees, is determinative: until the federal law is changed, states which employ transfer rules are in violation of existing law. By definition, the fact that federal law does not presently permit transfer rules, and forbids states to apply prohibitions against them, has led Congress to pass this legislation.

The new legislation provides for a comprehensive resolution of the "problem", as the federal government now sees it. First, for applications for SSI after February, 1981, see Publ.L. 96-611, §5(c), resources transferred within the last 24 months will be considered available unless the applicant "furnishes convincing evidence to establish that the transaction was exclusively for" a purpose other than to obtain eligibility. Section 1613(c)(2) of the Social

Security Act, as added by Pub.L. 96-611, §5(a). In effect, this will result in a denial of SSI eligibility for 24 months after the date on which the resource was transferred.

The second part of the amendment deals exclusively with Medicaid eligibility. Pub.L. 96-611, §5(b). It adds a new provision to the Medicaid statute, section 1902(j) of the Social Security Act. First, it specifies that a state may amend its state plan to deny Medicaid to an individual who transfers in order to obtain eligibility, but, with one exception, the state must implement that procedure in a manner "no more restrictive than the procedure applied in section 1613(c) of this Act." Section 1902(j)(1) of the Social Security Act, as added by Pub. L. 96-611, §5(b). Through this subsection (j)(1), Congress has continued the general requirement that states' Medicaid eligibility conditions cannot be more restrictive than the SSI eligibility conditions, but can be less restrictive. Moreover, while the SSI transfer rule is mandatory, states have been given the option of applying one to Medicaid applicants.

The one exception to the requirement that the state impose a no less liberal Medicaid rule than that for SSI is set out in subsection (j)(2). It allows a state, in those instances in which the "uncompensated" portion of the transferred asset is valued at over $12,000, to impose a period of ineligibility greater than 24 months. By contrast, the SSI transfer rule in the new section 1613(c) of the Social Security Act (added by §5(a) of the new law) precludes a state from considering the transferred resource available after 24 months have elapsed. Thus, the longest conceivable period of ineligibility for SSI would be 24 months. Senator Long explained this one exception in these terms:

> "The amendment would permit States to establish disposal of assets disqualification rules for

medicaid purposes which differ in detail from the SSI rule. Generally, State rules could not be more restrictive than the federal SSI rule except that the period of disqualification could be longer than 24 months in cases where a very large disposal of assets -- more than $12,000 -- is involved." 126 Cong.Rec. S16505-16506 (daily ed., Dec. 13, 1980).

Subsection (j)(3) of the new Medicaid statute resolves any doubts which might otherwise have been created by allowing states to use a less restrictive Medicaid transfer rule than is used in the SSI program. It specifies that although an individual may be found ineligible for SSI under section 1613(c), the state may still provide Medicaid coverage under those rules which the state adopts pursuant to subsections (j)(1) and (j)(2). This provision guarantees that a state will be reimbursed for Medicaid coverage provided to an individual not eligible for SSI by reason of the SSI transfer provision in section 1613(c).2/

Finally, the effective date section, section 5(c), is explicitly only applicable to section 5(a), the amendment to the SSI statute (Title XVI of the Social Security Act).

2/ An example demonstrates how this might work. Pursuant to subsection (j)(2), a state might elect to employ a period of ineligibility greater than 24 months for an asset valued over $12,000, while deciding pursuant to subsection (j)(1) to apply the transfer rule only to transfers which take place twelve months prior to application for Medicaid. Thus, someone who transferred property worth $13,000 fifteen months prior to applying for SSI and Medicaid could be found ineligible for SSI, but eligible for Medicaid. Subsection (j)(3) thus ensures that states are not restricted to all aspects of the SSI transfer rule.

///

Since the legislation was signed on December 28, 1980, the SSI transfer rule will take effect on March 1, 1981. Only applications for SSI after that date are subject to the transfer rule.

By contrast, there is no specific effective date section for that portion of the law which adds subsection (j) to the Medicaid statute. This provision therefore is subject to the law's general effective date of July 1, 1981. Pub.L. 96-611, §2. Thus, starting July 1, 1981, states may employ a limited transfer rule against Medicaid applicants.3/

3/ Setting a later effective date for the Medicaid rule represents a recognition of the more complicated process of introducing new Medicaid provisions. HHS will need to develop regulations to implement those provisions, and to specify the limits within which the states can establish their Medicaid transfer of assets rule. States which do not have transfer rules because they recognized their illegality or because they have been invalidated may want to consider adding such a provision, which will require state legislative and administrative action. States which have rules -- now illegal -- will have to determine whether those rules need to be altered to meet the federal requirements. And any state which opts to employ a transfer rule will have to decide whether to use the SSI rules or more liberal requirements, and whether to establish a longer period of ineligibility in the appropriate circumstance. Moreover, any state which decides to use such a rule will need to have its new state plan approved by HHS. See 1902(j)(1) of the Social Security Act, as added by Pub.L. 96-611, §5(b). In short, it is likely to require at least six months for the federal and state

(cont. on p. 6)

Consequently, for those members of the class who have applied for Medicaid, or who will apply prior to July 1, 1981, California is not permitted to employ a transfer of assets rule to deny eligibility. The sponsors of the bill were explicit about this, and the manner in which it was structured further indicates that they fully understood the correctness of plaintiff's position concerning the relationship between the SSI and Medicaid statutes. While the issue may not be subject to simple resolution for those class members who apply after the effective date, see infra, at 9-10, the present impropriety of the California transfer rule has now been conclusively and undoubtedly established.

B. In light of the explicit Congressional recognition of present federal law, the decision below should be reversed without further briefing or argument.

The courts below should have recognized the propriety of plaintiffs' claims, and this Court should have been in the position of simply affirming the decision of the Court of Appeals. This Court took that action in a case involving a similar intervening change in the law. In Lascaris v. Shirley, 420 U.S. 730 (1975), the Court considered New York's appeal of the decision of a three-judge court holding a portion of that State's AFDC law invalid as in conflict with the relevant portion of the Social Security Act. After this Court noted

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3/ (cont.)

bureaucracies to make the decisions and changes necessary to implement the Medicaid transfer rule. Until that time, though, there is no federal support for the application of a transfer of assets rule to Medicaid applicants.

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probable jurisdiction, the federal law was "amended ... expressly to resolve the conflict as to eligibility found ... to exist between the federal and state laws." 420 U.S. at 731. This Court thus affirmed, since the explicit change in the federal law rendered it clear that the state law prior to the amendment had been correctly perceived by the district court as in violation of federal law. The Court noted that there was "no occasion to prepare an extended opinion." Id., at 733.

The only distinctions between that case and this one are insignificant. In Lascaris, oral argument had taken place before the change in the federal law. But given the explicit purpose of Pub.L. 96-611, oral argument in this case will shed no further light on the issues. Whatever the precise contours of the new federal law, there can be no doubt that its express goal was to provide a federal basis for states to take action which is now totally impermissible.

Also, in Lascaris, the Court was affirming, rather than reversing. But that is a distinction without a difference. The Court can reverse summarily at this time, just as it could have if the intervening legislation had been signed before the petition for certiorari had been ruled on. Nothing in Rule 23.1 suggests that "a summary disposition on the merits" is limited to affirmances.

Indeed, on several recent occasions, this Court has recognized the propriety of reversing lower courts without full briefing and oral argument. Stone v. Graham, -- U.S. --, 101 S.Ct. 192 (1980), rev'g 599 S.W.2d 157 (Ky.1980); Allied Chemical Corp. v. Daiflon, Inc., -- U.S. --, 101 S.Ct. 188 (1980), rev'g sub nom. Daiflon, Inc. v. Bohanon, 612 F.2d 1249 (10th Cir. 1979); Hughes v. Rowe, -- U.S. --, 101 S.Ct. 173 (1980), rev'g 605 F.2d 559 (7th Cir. 1979). In those

cases, however, the legal issue was nowhere near as clear cut as in this instance. Stone v. Graham, supra, 101 S.Ct., at 194, 195 (Burger, Ch.J., Blackmun, Stewart, Rehnquist, JJ.) (dissenting from decision on merits or from decision not to give plenary consideration); Allied Chemical Corp. v. Daiflon, Inc., supra, 101 S.Ct., at 191 (Blackmun, White, JJ.) (dissenting from decision not to give plenary consideration); Hughes v. Rowe, supra, 101 S.Ct., at 179 (Burger, Ch.J., Stewart, and Rehnquist, JJ.) (dissenting from part or all of the decision on the merits or from decision not to give plenary consideration). Here, Congress, dissatisfied with existing law, has set a date for a change in that law. Until then, however, Congress has left no doubt that present federal law forbids the challenged California procedure. Had Congress passed that provision prior to this Court's decision to grant certiorari (on November 3, 1980), this would have been an ideal case to reverse without plenary consideration. The fact that the petition was granted, and briefing had begun, should not affect the propriety of summary reversal.

The California transfer rule is in direct violation of existing federal law, and will remain in violation at least until July 1, 1981. Relief must be provided both for past and continuing violations and to prevent future violations. This Court should therefore reverse with directions to enjoin the continued application of the transfer rule. Furthermore, it should remand to the Ninth Circuit with orders that a procedure be established for notifying class members of their right to obtain reimbursement through a state administrative process. Relief of this nature has been requested at every stage of this litigation, see Complaint (J.A. 11); Dawson v. Myers, 622 F.2d 1304, 1315 n.13

(9th Cir. 1980) (J.A. 73), and it is appropriate and permissible under the Eleventh Amendment. Quern v. Jordan, 440 U.S. 332 (1979).

The new federal provision leaves no doubt that the California transfer rule violates federal law now in effect, and has violated federal law during the entire course of this litigation. Class members whose applications for eligibility will not be subject to the new provision are entitled to injunctive and declaratory relief, and to the opportunity to obtain reimbursement, where appropriate.

II. THE DECISION BELOW SHOULD BE VACATED AND REMANDED FOR THOSE MEMBERS OF THE CLASS WHO WILL APPLY ON OR AFTER JULY 1, 1981

Reversing the decision of the Court of Appeals is only appropriate for those class members who have already applied and been denied benefits, or who will apply before the effective date of the new federal statute, July 1, 1981. For those applying on or after that date, however, there will no longer be a contrary federal law. It is undeniable that states will be able to employ transfer of assets rules; the question then becomes whether the California rule meets the requirements of the federal law and regulations.

It would be inappropriate for this Court to make that determination in the present context of this case. A number of issues surrounding the new federal law will need to be resolved. For instance, what is "convincing evidence" to overcome the presumption? See section 1613(c)(2) of the Social Security Act, as added by Pub.L. 96-611, §5(a). Another problem will be establishing whether a period of ineligibility greater than 24 months "bear[s] a reasonable

relationship to [the] uncompensated value." See section 1902(j)(2) of the Social Secuirty Act, as added by Pub.L. 96-611, §5(b). HHS will have to develop regulations dealing with these and other issues, and the states will be required to submit their state plans to HHS for evaluation.

Only after these steps are undertaken over the course of the next six months will it be proper for the courts to determine whether the California provision comports with the new federal requirements. At that time, the district court can make that determination. New class representatives may need to be appointed to act on behalf of that portion of the existing class who apply after June 30, 1981 and have their claims denied. Kremens v. Bartley, 431 U.S. 119, 135 (1977).

Consequently, the appropriate course for that portion of the class is to vacate the decision of the Court of Appeals, and to remand. The case should be returned so that the district court may determine whether the California provision complies with the federal law as it is implemented on July 1, 1981.

CONCLUSION

For those class members who have been denied Medi-Cal in the past, or who are still being denied Medi-Cal, or who will be denied Medi-Cal after an application made prior to July 1, 1981, the decision of the Ninth Circuit should be reversed without further briefing or argument, with the case remanded for the entry of an order enjoining the continued application of the California transfer of assets rule and providing for relief within the state administrative system to those who have already lost benefits.

For those class members who will apply after June

30, 1981 for Medi-Cal, the decision of the Ninth Circuit should be vacated and remanded without further briefing or argument, with the case remanded for further proceedings in light of the intervening federal law.

Respectfully submitted,

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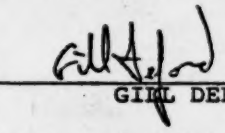
DATED: January 9, 1981. By 
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CERTIFICATE OF SERVICE

I, Gill Deford, a member of the bar of the Supreme Court, do hereby certify that I have served on this 10th day of January, 1981, one copy of MOTION OF PETITIONER FOR SUMMARY REVERSAL AND REMAND IN PART, AND FOR VACATION AND REMAND IN PART DUE TO INTERVENING LEGISLATION, with postage thereon fully prepaid, in the United States Mail at Los Angeles, California, addressed to:

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I further certify that all parties required to be served have been served.

Gill Deford

GILL DEFORD

Attorney for Plaintiff

No. 80-5303

In the Supreme Court of the United States

OCTOBER TERM, 1980

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHER SIMILARLY SITUATED, PETITIONER,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH, RESPONDENTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED AUGUST 27, 1980
CERTIORARI GRANTED NOVEMBER 3, 1980

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IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA:

Complaint in Intervention for Declaratory and Injunctive Relief, filed February 26, 1979

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Opinion, filed May 14, 1980

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. C 78 -2350 MML(Sx)

ROSSYE DAWSON, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, PLAINTIFF

vs.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, INTERVENOR-PLAINTIFFS.

COMPLAINT IN INTERVENTION FOR DECLARATORY AND INJUNCTIVE RELIEF FILED FEBRUARY 26, 1979

CLASS ACTION

INTRODUCTION

1. This class action challenges the failure of the State of California to provide Medicaid benefits (referred to in California as "Medi-cal") to individuals otherwise eligible because of the State's application of an additional eligibility requirement which does not comport with controlling federal law.

JURISDICTION

2. Jurisdiction is invoked pursuant to 28 U.S.C. § 1343 (3) and (4), which provide for original jurisdiction of this court over actions authorized by 42 U.S.C. § 1983 to redress the deprivation of rights under color of state law. Jurisdiction is also conferred by 28 U.S.C. § 1331, as there is more than $10,000 in controversy; an actual controversy

does exist and plaintiff seeks a declaration of rights pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201, 2202.

PARTIES

3. Intervenor-plaintiff ANTONIA BELTRAN is an eighty-six (86) year old resident of Los Angeles, California, who requires, and who, because of physical frailty, will continue to require, long-term care in a nursing home facility.

4. Intervenor-plaintiff ENOSINSIO MANAHAN is an eighty-five (85) year old long term care patient living in a convalescent home in Anaheim, California. Because of age-related, severe illness, he requires and will continue to require long-term care in a nursing home facility.

5. Defendant EDWARD BEACH is the former Director of the State Department of Health Services, and pursuant to Rule 25(d)(1), F.R.Civ.P., his successor is automatically substituted as a party. His successor and the present Director of the State Department of Health Services is Beverly A. Myers, and as Director she is responsible for the overall administration of the Medi-Cal Program.

6. Defendant BRUCE YARWOOD is the Deputy Director of the State Department of Health Services and is in charge of the Medi-Cal Division of the Department.

CLASS ACTION ALLEGATIONS

7. Intervenors Beltran and Manahan bring this action on their own behalf and, pursuant to Rules 23(c) and 23(b)(2) of the Federal Rules of Civil Procedure, as the representatives of a class consisting of all aged, blind, and disabled individuals who have been, are being, or will be, denied Medi-Cal benefits because of an alleged transfer of assets for inadequate consideration pursuant to Welfare and Institutions Code ("W.&I.C."), Section 14015, and 22 Cal. Admin. Code § 50409. The class is so numerous that joinder of all its members is impracticable. There are questions of law and fact common to the class. Intervenors' claims are typical of the claims of all class mem-

bers, and intervenors will fairly and adequately protect the interests of the class. In addition, defendants have acted and continue to act on grounds generally applicable to all members of the class, thereby making appropriate declaratory and injunctive relief with respect to the class as a whole.

STATUTORY AND REGULATORY FRAMEWORK

8. The Medical Assistance Program (referred to generally as "Medicaid") is a cooperative federal-state program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq*. In accordance with the Act, the Secretary of the Department of Health, Education and Welfare promulgates regulations which, in addition to the statutes, provide the framework in which the states must develop and operate their Medicaid programs.

9. California has chosen to participate in the Medicaid program, and, consequently, the responsible state agency, the State Department of Health Services, is required to administer the program in compliance with federal standards.

10. Among the categories of individuals who, if they meet income eligibility guidelines, are eligible for Medicaid, are the aged (over 65), blind, and disabled.

11. Under federal law, all recipients of Supplemental Security Income ("SSI"), the federal cash benefit program for the needy aged, blind and disabled, are automatically eligible for Medicaid benefits. These eligibles are known as the "categorically needy." (Certain other groups, not here involved, are also among the categorically needy.)

12. In addition, states have the option, pursuant to 42 U.S.C. § 1396a(a)(10)(C), of providing Medicaid benefits to individuals who meet the categorical definitions (i.e., aged, blind or disabled) but who are not financially eligible. Known as the "medically needy", they may gain eligibility for Medicaid by spending down on medical needs to the eligibility level. California has a medically needy program for its aged, blind and disabled.

13. In the SSI program, the transfer of assets prior to application for less than full consideration is not a relevant factor in determining eligibility.

14. Under California law, transfer of property for less than adequate consideration is specifically noted as an exception to the rule that the provision of health care will not be restricted by property holdings. Under W.&I.C. § 14015,

> any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director . . . .

15. The state regulations implementing this provision provide, *inter alia*, that:

> To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand the extent of resources.
>
> (A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumptions. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.
>
> (B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability of genefits of the Medi-Cal program is not sufficient to overcome the presumption.22 Cal.Admin.Code § 50409(b)(2).

16. Once a determination is made that a transfer was effected improperly,

there shall be a period of ineligibility. This period shall be the time during which the net market value of the property at the time of transfer, less consideration received, would have supported the applicant or beneficiary and the applicant's or beneficiary's family.

22 Cal.Admin.Code § 50411(a).

FACTUAL STATEMENT

17. Intervenor Antonia Beltran requires long-term care in an institutional setting, and is expected to continue to require such care for the indefinite future. She lived in her own home with her husband, Philip, until March, 1978, when her overall weakness required her to go to a convalescent home. She has remained in convalescent homes since that time, and is presently living in the Santa Teresita extended care facility in Duarte, California.

18. On February 23, 1977, she and her husband, Philip, grant-deeded their home in East Los Angeles to their three children, Philip, Emilio, and Josephine. The deed was recorded on March 7, 1977. After deeding the home, they continued to live in it until Mrs. Beltran was forced to leave in March, 1978. Mr. Beltran has continued to live in the home to this day. In May, 1977, both of them were found eligible for Medi-Cal under the state's medically needy program.

19. In the summer of 1978, Antonia Beltran was notified that her Medi-Cal would be terminated. It was terminated effective September 1, 1978, and she has not received Medi-Cal benefits since that time. Her husband, Philip, has continued to receive Medi-Cal benefits.

20. In the fall of 1978, Mrs. Beltran applied again for Medi-Cal benefits. This application was denied in a Notice of Action dated January 8, 1979. A copy of that Notice of Action is attached to this complaint as Exhibit "A".

21. The Notice of Action indicates that the Beltrans' transfer of property in the winter of 1977 is the cause of this denial. According to the Notice of Action, unless certain other conditions are met, Mrs. Beltran will remain in-

eligible for Medi-Cal for the next eight hundred eighty-five (885) months, a period of more than 71 years.

22. Intervenor Enosinsio Manahan is an eighty-five (85) year old long-term care patient living at the Fountainbleau Convalescent Home, 3415 West Ball Road, Anaheim, California. Because of advancing diabetes mellitus and senile dementia, he requires long-term care in an institutional setting and is expected to continue to require such care for the indefinite future.

23. Mr. Manahan entered the convalescent home in January, 1977, and since then has been separated and living apart from his wife, Lucy Manahan. Mrs. Manahan resides with her daughter by a previous marriage, Mrs. Lucille Tom, to whom she pays monthly rent.

24. On April 12, 1978, application for Medi-Cal was made on Ensinsio Manahan's behalf by his step-daughter, Mrs. Lucille Tom, at the Orange County Department of Social Services.

25. On June 5, 1978, the Orange County Department of Social Services denied Medi-Cal eligibility for Enosinsio Manahan, on the grounds of a transfer of assets for inadequate consideration pursuant to Welfare and Institutions Code § 14015 and 22 Cal. Admin. Code § 50409. This denial was based on sale of the family home by Mrs. Manahan in May, 1977, four months after Enosinsio Manahan entered the convalescent home and eleven months before the application for Medi-Cal was made. (Exhibit "B", attached to the complaint.)

26. On July 6 and 7, 1978, a Fair Hearing was held on whether Orange County correctly denied Mr. Manahan's application for Medi-Cal benefits because of its determination that he transferred property in order to become eligible.

27. The Hearing Officer recommended that Orange County rescind its denial of the claimant's Medi-Cal application and that Mr. Manahan be allowed to spend down $1,630.98 in order to meet the property limit for Medi-Cal. (Exhibit "C", attached to the complaint.)

28. On January 12, 1979, the Director of the State Department of Health Services overturned the decision of the hearing officer, and ruled that Orange County correctly applied Section 50409(b) in denying Mr. Manahan's Medi-Cal application. The Director ruled that Mr. Manahan received a community property share from the proceeds of the sale of the home, and that he has not overcome the presumption that the transfer of property was for the purpose of establishing eligibility. (Exhibit "D", attached to the complaint.)

29. The present outstanding balance to the nursing home for cost of his care is $8,944.93.

IRREPARABLE INJURY

INADEQUACY OF REMEDY AT LAW

30. Defendant's determination that plaintiff-intervenors are ineligible for Medi-Cal benefits has caused them irreparable harm, and continues to cause them irreparable harm, in that they are incapable of paying for the cost of necessary institutionalized care with their own incomes. Without Medi-Cal benefits, they will be forced to leave the institution.

31. There is no adequate remedy at law. Defendants are depriving intervenors and their class of necessary health care, and this harm is not susceptible of redress by a mere award of money damages. Only injunctive relief can insure the provision of health care to intervenors and their class.

FIRST CAUSE OF ACTION

32. California has chosen to provide Medi-Cal benefits automatically to all recipients of SSI.

33. The SSI program does not predicate eligibility on a transfer of assets for adequate consideration prior to application. In order to meet the requirement that it provide Medi-Cal benefits to all SSI recipients, California cannot utilize a transfer of assets provision for its categorically needy program.

34. Pursuant to section 1902(a)(10)(C)(i) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(C)(i), a state is precluded from applying more restrictive eligibility conditions to the medically needy than the categorically needy.

35. Additionally, federal regulations require that a state use resource standards equal to the higher of the state's standards in the Aid to Families with Dependent Children (AFDC) or SSI programs. 42 C.F.R. § 435.840(a), at 43 Fed. Reg. 45216 (September 29, 1978). [In the September 29, 1978, Federal Register, HEW reworded and recodified, but with no substantive changes, all of its Medicaid regulations. 43 Fed. Reg. 45716, *et seq.* Title 42 C.F.R. § 435.840(a) is equivalent to the former 42 C.F.R. § 448.3(c)(1)(iv), which was itself previously codified at 45 C.F.R. § 248.3(c)(1)(iv).]

36. By requiring that assets be transferred for adequate consideration in order to be eligible for Medi-Cal, defendants are applying an eligibility condition more restrictive than that utilized in the SSI program, and thereby are in violation of federal statutory and regulatory requirements.

SECOND CAUSE OF ACTION

37. Pursuant to 42 U.S.C. § 1396a(a)(17), states are permitted to consider only income and resources which are actually available to the recipient. By deeming the value of a former property available to them when in fact neither that property nor its cash value is available, defendants are violating this federal requirement

THIRD CAUSE OF ACTION

38. By requiring applicants to demonstrate that they disposed of assets for adequate consideration prior to application, defendants have added an additional eligibility condition which is nowhere found in the Social Security Act. Such additional eligibility conditions are in violation of the Supremacy Clause of the Constitution.

FOURTH CAUSE OF ACTION

39. Section 50409 of Title XXII, California Administrative Code, represents a conclusive presumption that any transfers of assets within a two-year period prior to application are for the purpose of qualifying for aid. Section 14015, W.&I.C., conclusively presumes that any transfer for inadequate consideration is for the purpose of obtaining Medi-Cal benefits. There is no realistic opportunity to rebut these presumptions, as section 50409(b)(2) of the California Administrative Code does not permit any proof of "subjective intent." There is no logical nexus between the basic fact of the transfer for inadequate consideration and the presumed fact of transfer to obtain benefits.

FIFTH CAUSE OF ACTION

40. The transfer of assets rule has created two classes of aged, blind and disabled individuals. One class consists of those aged, blind and disabled who are automatically eligible for Medi-Cal benefits without regard to any transfer of assets that they may have made prior to applying for Medi-Cal. The other class consists of those aged, blind and disabled who, like the first class, are in need of health care but who are not eligible for SSI benefits and are therefore subject to the transfer of assets rule in applying for Medi-Cal. This classification is arbitrary and irrational, and serves no legitimate purpose. It is contrary to a major goal of the Medicaid program, to provide health care to needy aged, blind and disabled individuals unable to pay for their own care. Such arbitrary and irrational classifications violate the equal protection clause of the 14th Amendment.

PRAYER FOR RELIEF

WHEREFORE, intervenors respectfully pray on behalf of themselves and all others similarly situated that this Court:

1. Assume jurisdiction over this case.

2. Certify by order at an appropriate time that this suit is properly maintainable as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure.

3. Declare that defendants' policy of terminating Medical eligibility due to an alleged transfer of assets without adequate consideration prior to applying for Medi-Cal, as expressed in W.&I.C. § 14015 and 22 Cal.Admin.Code § 50409, violates controlling federal law and implementing regulations, and the equal protection and due process clauses of the Fourteenth Amendment to the United States Constitution.

4. Enter a permanent injunction restraining defendants, their successors in office, agents, and employees, and all persons acting in concert with them, from denying Medi-Cal benefits to the intervening plaintiffs and all members of their class for the reason that they allegedly transferred assets prior to application without due consideration.

5. Order defendant to notify all members of the class that their ineligibility for Medi-Cal due to a transfer of property without due consideration has been re-evaluated and that if they are otherwise eligible: (1) they may reapply for Medi-Cal without regard to any previous transfer of assets; and (2) that they may request reimbursement for these amounts which they were forced to spend on medical care during the period of ineligibility based on a transfer of assets which would otherwise have been covered by Medi-Cal.

6. Award intervenors the costs of this suit, including reasonable attorneys fees.

7. Grant such other and further relief as to the Court seems just and proper.

DATED: February 8, 1979.

Respectfully submitted,

DANIEL HANTMAN
IRENE CARDEANS GALLARDO
PAUL HENRY ABRAM
RONALD L. TAYLOR
RICHARD ROSS
GARY ROWSE
GILL DEFORD
NEAL DUDOVITZ
STUART PARKER

By _____
GILL DEFORD
Attorneys for Plaintiffs

MEDI-CAL
NOTICE OF ACTION
DENIAL/DISCONTINUANCE
OF BENEFITS

Medi-Cal Central District #80
1801 W. Valley Blvd.
P.O. Box 2630
Alhambra, CA 91803

Antonia Beltran
% Philip Beltran
1111½ So. Lorena St.
Los Angeles, CA. 90023

State No. 5243322
District: 80
Denial/discontinuance for:
Antonia Beltran

We have reviewed all information available to us about your circumstances, and we find that:

☒ Your application for Medi-Cal dated 10/27/78 has been denied.

☐ Your eligibility to receive Medi-Cal will be discontinued effective the last day of _____.
(Month)

The reason for this denial/discontinuance is: the value of the property you transferred on 3-7-77 causes your property reserve to exceed the allowable maximum. You are ineligible for a period of 285 months, or until you have spent the excess value of $22,121,000 in medical bills. Your period of ineligibility will also expire if your property is returned to you or if you receive fair price for the property you transferred.

☐ You did not return your completed RECORD OF HEALTH CARE COSTS form for _____
(Month)

and so did not receive a Medi-Cal card. We will assume that you wish to have your Medi-Cal eligibility discontinued unless you request a RECORD OF HEALTH CARE COSTS form for _____ (Month) from this office by _____ (date). If we do not hear from you, your eligibility will be discontinued effective the last day of _____ (Month).

The regulations which require this action are California Administrative Code, Title 22, Section(s): 50411.2.24

EXHIBIT "A"

PERIOD OF INELIGIBILITY

If you are eligible for Medicare and your Medi-Cal eligibility is discontinued, this means that _____ is the
(Month)
last month the State will pay your premium for supplementary insurance coverage (Part B Medicare). You will receive a written notice from the Social Security Administration, or you may call your Social Security District Office if you have any questions about your Medicare status.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us, and that you may reapply at any time.

T Live	576-1261	1-8-79
(Eligibility Worker)	(Phone)	(dated)

EXHIBIT "A"

MEDI-CAL
NOTICE OF ACTION
DENIAL/DISCONTINUANCE
OF BENEFITS

HUMAN SERVICES AGENCY/
SOCIAL SERVICES
1624 W. 19th STREET
P.O. Box 1999
SANTA ANA, CALIFORNIA 92702

Enosinsio Manahan
15261 Swallow Lane
Westminster, Ca. 92683

State No. 3013-0315454
District: 09
Denial/discontinuance for:
MANAHAN, Enosinsio

We have reviewed all information available to us about your circumstances, and we find that:

☐ Your application for Medi-Cal dated 4/12/78 has been denied.

☐ Your eligibility to receive Medi-Cal will be discontinued effective the last day of _____.
(Month)

The reason for this denial/discontinuance is: A period of ineligibility exists starting 5/77 and are allowing expenditures from transferred property at the rate of the State maintenance Needs of $278. This accounts for approx. $3600. of the transferred property for the period 5/77-5/78. Therefore, as of 6/78 we have determined the remainder of monies transferred without adequate consideration to be $50,342. based on the information you provided on proceeds from sale of your home. (see attached.)

☐ You did not return your completed RECORD OF HEALTH CARE COSTS form for _____ and
(Month)
so did not receive a Medi-Cal card. We will assume that you wish to have your Medi-Cal eligibility discontinued unless you request a RECORD OF HEALTH CARE COSTS form for _____ from this
(Month)
office by _____. If we do not hear from
(Date)
you, your eligibility will be discontinued effective the last day of _____.
(Month)

EXHIBIT "B"

The regulations which require this action are California Administrative Code, Title 22, Secton(s): 50409, 50096,50411

If you are eligible for Medicare and your Medi-Cal eligibility is discontinued, this means that_____
(Month)
is the last month the State will pay your premium for supplementary insurance coverage (Part B Medicare). You will receive a written notice from the Social Security Administration, or you may call your Social Security District Office if you have any questions about your Medicare status.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us, and that you may reapply at any time.

Patty Fleming	834-6152	6-5-78
(Eligibility Worker)	(Phone)	(Dated)

MANAHAN, Enosinsio
3013-0315454

Medi-Cal Notice of Action

You will not be eligible until these monies are expended at a rate of $25.00 per month for Mr. Manahan, plus $253.00 per month for Mrs. Manahan, plus substantiated medical expenses.

EXHIBIT "B"

CALIFORNIA DEPARTMENT OF
HEALTH SERVICES

Fair Hearing No. 78163110 OR
State No. 30-13-315454
District

03 030 01 1

IN THE MATTER OF THE HEARING OF CLAIMANT
ENOSINSIO MANAHAN
15261 Shallow Lane
Westminister, CA 92683

Hearing Officer: ERNESTO J. PEREZ
Country Representative: JOHN JACOBS
Authorized Representative: TIM FLYNN
Place: Santa Ana, California

Date of Hearing: July 6 & 7, 1978*
Date of County Notice: June 5, 1978
Fair Hearing Filing Date: June 8, 1978
Air Paid Pending: N/A (Denial Action)

PROPOSED DECISION

ISSUE

The issue for resolution is whether Orange County correctly denied the claimant's April 12, 1978 application for Long-Term Care California Medical Assistance Program (Medi-Cal) benefits because of its determination that he transferred property in order to become eligible.

STATEMENT OF FACT

COUNTY ACTION AND POSITION:

Orange County took the above-action after determining that the claimant's community property share of the

* Record left open until July 28, 1978 for the claimant to submit additional documents. Such information was received, and the record was closed on August 15, 1978. The county did not submit rebuttal evidence.

EXHIBIT "C"

$75,000 proceeds from the sale of his home in May 1977 had been transferred for the purpose of establishing program eligibility. In evaluating the disposition of the $75,000, the county accepted the following transactions as acceptable dispositions:

1. Claimant's medical expenses	$ 8,381.88
2. Spouse's medical expenses	2,240.14
3. Claimant's and spouse's personal expenses	5,466.68
4. Burial plots for claimant and spouse	1,969.10
TOTAL:	$18,057.80

After allowing the $18,057.80 expense, Orange County identified $56,942.20 as the community property remaining from the sale of the home ($75,000.00—$18,057.80 = $56,942.20. The remainder was then halved to determine the claimant's community property share from the proceeds of the sale of his home (½ × $56,942.20 = $27,648.65). As the claimant declared ownership of a $2,999.96 savings account in his own name on the date of application, the county contends that he has failed to verify the disposition of $24,648.69 remaining from his share from the transfer of his home. Inspection of that account by the Hearing Officer established that the monies are under the name of the claimant's spouse and her daughter (not adopted by claimant). Since that transfer (creation of accounts and expenditures therefrom) occurred within two years of this application it is Orange County's position that according to Title 22, California Administrative Code (CAC), Section 50400(b) the claimant now has the burden of demonstrating by objective facts (rather than by statements of objective intents) that he did not dispose of $24,648.69 for the purpose of establishing program eligibility. Assuming that the claimant is unable to overcome the presumption that he transferred his funds in order to establish program eligibility, the county stated that since he is currently in long-term care status he will become eligible for program participation at that point when a $25 monthly maintenance allowance (plus verified paid medical expenses) reduces his property

holdings below the $1,500 limit for a one-person Medi-Cal Family Budget Unit (MFBU).

Orange County rejected the claimant's Authorized Representative (AR) argument that the $75,000 proceeds from the sale of his home were the separate property of his spouse. The county stated that although the purchase of that property may have initially been made possible as the result of a gift or loan of money from the claimant's spouse's mother directly to her daughter, the claimant's spouse's testimony at the hearing established that these monies were repaid by the claimant's spouse during their marriage from the claimant's spouse's earnings. The county therefore reasoned that property obtained during the marriage by use of a community property fund (earned income) becomes community property and is no longer the separate property of either spouse. Additionally, the county pointed out that the only property which it alleged to be owned by the claimant was the real property sold in 1977, in which the claimant was recorded by title deed as a joint tenant in conjunction with his spouse.

Orange County refused to allow $18,476 expenditures as reductions of the claimant's personal property holdings which the claimant's spouse's daughter claimed to have been paid from the May 1977 property sale proceeds for "loan commitments." The county explained that affidavits submitted to establish the occurrence of these transactions are not sufficient to show that they were transfers to satisfy legal debts because of the following:

1. All transactions were between the claimant and friends or relatives. The county submits that where the relationships of contracting parties are personal, the requirements of Title 22, CAC, Section 50409(b) impose a high standard of proof to establish that the transactions were legally valid. Absent pre-existing evidence regarding how the obligations were incurred by the claimant, the county submits that mere written statements by those who received funds are insufficient;

2. The affidavit by the claimant's spouse's daughter stating that she was paid $1,000 does not indicate what the $1,000 was paid for;
3. The affidavit stating that the claimant's spouse's son-in-law was repaid $2,176.10 fails to indicate what the money was owed for and how it was originally provided; and that
4. Three affidavits accounting for the receipt of $15,300 are vague as to when the monies or services were provided. Additionally, Orange County argued that the fact that one affidavit is undated and the other two are dated after April 19, 1978, establishes that no previously-existing debts actually occurred between these recipients and the claimant.

Notwithstanding its position that the $18,476 paid to the claimant's spouse's daughter, the claimant's spouse's son-in-law, and three other friends or relatives was not a transfer to satisfy a legal debt, the county pointed out that even had it acknowledged such an amount as a valid disposition of the claimant's property, his remaining holdings still render him ineligible for current enrollment in the Medi-Cal program ($27,648.65–$18,476.00 = $9,172.65).

No evidence was introduced to show that the county completed an eligibility evaluation or advised the claimant of qualification by spenddown.

CLAIMANT'S POSITION:

The claimant's AR contended that Orange County had incorrectly treated $37,500 from the sale of a home in May 1977 as the claimant's community property share. He argued that the claimant had no community property share in that property because it represented a 1963 transfer of $7,500 paid to the claimant's spouse by her mother as a partial inheritance and for the services rendered to her by her daughter.

Alternatively, it was argued that the family had properly accounted for the disposition of the claimant's interest in the proceeds from the May 1977 sale.

Records and deeds were submitted to show the following disposition of the $75,000:

1. Proceeds from home: Gross Sales Price (Contract price plus taxes)		$75,403.43
2. Less Closing Costs		
a. Settlement charges		$ 542.25
b. Payoff of second mortgage		9,421.59
c. Interest for second mortgage payoff		53.99
d. Statement fee	+	15.00
e. Reconveyance fee		25.00
		($10,057.83)
3. Cash due (1-2)		− 10,057.83
		$65,345.60

Of the remaining cash due ($65,345.60), $25,000 was received in the form of a second trust deed on the property, payable to the claimant's spouse and her daughter as joint tenants and as their sole and separate property. The terms of the trust deed note provide that 3 percent interest will be paid annually and that monthly installments of not less $225 for a period of ten years shall be paid against the principal. On February 6, 1978, this trust deed was transferred to the claimant's spouse's daughter as her separate property. In reviewing a title search abstract provided by the Title Search Section of the Los Angeles County Department of Public Social Services, the record indicates that the $25,000 trust deed is a product from the sale of the claimant's property in May 1977 in which he held a joint tenancy with his spouse.

The AR argued that the $25,000 second trust deed should be excluded from consideration as the claimant's property because it represents the legacy which the claimant's spouse and her previous spouse intended for the claimant's non-adopted stepdaughter. The basis for this contention was testimony at the hearing by the claimant's

spouse and her daughter, but no documentary evidence (such as wills, letters, etc.) was provided.

Assuming the $25,000 is properly excluded, the AR then argued that the outstanding amount to be accounted for is $40,345.60 ($65,345.60 balance from home sale proceeds—$25,000.00 second trust deed). The claimant's spouse and her daughter testified that the remainder has been disposed of as follows: (Note: These are the transactions which Orange County has labeled unacceptable "loan commitments".)

1. Loan repayment to George Tom (spouse of claimant's spouse's daughter): $2,176.01

   Both testified that the claimant's spouse's daughter and her husband have assisted the claimant and his spouse since 1960 when the claimant retired. They explained that the claimant and his spouse only had Social Security income of about $3,600 annually plus whatever the claimant's spouse could earn by sewing. The claimant's spouse's daughter said that she and her husband helped pay: (1) the claimant's and his spouse's property taxes (which were up to $2,400 per year prior to the May 1977 sale), (2) medical expenses, (3) food and (4) miscellany. She said that because of the claimant's limited income, other members of the family also helped out during the last fifteen years.

   To prove that the money paid to the son-in-law was reimbursement for benefits received by the claimant and his spouse, cancelled checks written from January 21, 1977, through March 22, 1978 were introduced totalling $2,411.05. These checks were written by George Tom and made payable to the county tax assessor ($1,344.01), ambulance service companies ($240.40), doctors ($549.00), utility companies ($231.84) and miscellaneous ($45.80).

2. Loan Repayment to Lucille Tom: $1,000.00

   The claimant's spouse testified that her daughter (Lucille Tom) has helped her since the claimant retired.

EXHIBIT "C"

To show that the payment of this money was for an equal value of benefits received by the claimant, bank records were submitted to establish that on May 19, 1977, Lucille Tom made a $1,000 payment to Union Federal Savings as part of the closing costs on the sale of the claimant and his spouse's home. A review of the bank records by the Hearing Officer found that the account from which payment by Lucille was made was a joint account, in which the claimant's spouse was the other member. This account (#144374) was opened on May 16, 1977, with a deposit of $37,845.60 from the proceeds of the sale of the home. On April 25, 1978, its balance was $262.01.

3. Loan Repayment to Sidney Loquet: $10,000.00

The claimant's spouse testified that the above is her nephew and that she raised him after he became an orphan. She explained that because of her care she believed that Mr. Loquet had felt a moral obligation to assist her and her spouse when he became an adult. This help was received by Mr. Loquet paying for an eye surgery operation, clothing and insurance at the rate of about $20 monthly over a 15-year-period. The claimant's spouse's daughter said that she believed Mr. Loquet had provided at least $10,000 in benefits during the past. No other evidence was introduced to document the claimant and his spouse's indebtedness to Mr. Loquet.

4. Payment for services rendered by Ernest Orozco: $3,300.00

The claimant's spouse explained that Mr. Orozco (the claimant's spouse's nephew) worked for her and her spouse for 9 months (August 1976 through April 1977) as a caretaker of their home. She said that he maintained the yard, drove the claimant to the doctor, and house-sat. His services included painting the house, stripping the floors, and generally getting it into condition for sale. She stated that it was agreed that he

would be paid about $3,000 for his work when he started.

5. Loan repayment to Gertrude Podolinski: $2,000.00

The claimant's spouse testified that Ms. Podolinski (her niece) has provided benefits during the past to the claimant by paying insurance premiums and gifts. To document this obligation, cancelled checks were submitted. Those checks totalled 14 in number, written during the period for December 10, 1972 through January 16, 1977, and ranging in amounts from $10 to $200 per check (totalling $530 in all). Four of the checks are marked "gift" by Ms. Podolinski, and four are marked "insurance". Those marked "insurance" total $95.

TOTAL DISPOSITION BY LOAN REPAYMENT
(1 + 2 + 3 + 4 + 5) $18,476.01

Deducting the above expenditures, the AR contends results in a remaining property from the home sale proceeds of $21,869.59 ($40,345.60 balance from home sale proceeds—$18,476.01). By then deducting the $18,057.80 expenditures accepted by the county at the hearing, the amount remaining to be accounted for is $3,811.79 (21,869.59—$18,057.80), of which half must be deducted to preserve the claimant's spouse's community property share. When that halving occurs, the amount of the claimant's property remaining unaccounted for is $1,905.89 (½ × $3,811.79).

The Hearing Officer would like to note that his review of all documents and materials submitted at the hearing establish that the claimant is 84 years of age and has been in a nursing home since January 1977. According to his spouse's testimony, he concurred with her decision to sell their home in 1977, but she executed all the legal papers pursuant to a power of attorney which she has held for him since 1963. The claimant's signature does not appear in the sale of his home in 1977, on the transfers of the $25,000 trust deed, nor on any of the checks written from the account established from the proceeds of the 1977 sale. Addi-

tionally, a medical evaluation completed on July 5, 1978 by a medical doctor and a psychiatrist diagnose the claimant as having severe Dementia since December 1976. The psychiatrist reported: (1) that the claimant's ability to "comprehend and follow instructions" is "poor" (the lowest capacity rating provided in his reporting form), (2) severe memory defect, (3) moderately severe orientation defect, (4) moderately severe autistic or regressive behavior, (5) moderately severe illogical association of ideas, and (6) severe judgment defect, with no improvement expected. The medical doctor first saw the claimant on January 28, 1977, and his most recent examination was on July 1, 1978. June 30, 1978 was the date of the most recent psychiatric examination.

FINDINGS OF FACT

Since January 1977, the claimant has lacked a mental capacity to transact legal business. This finding is based on a review of the medical reports described in the Statement of Facts. Additionally, it is found that except for his oral agreement with his spouse in early-1977 that she should sell their home, he has not participated in making any decisions about the disposition of his property. This finding is based on the claimant's spouse's testimony and a review of all the documentary evidence—including the title deeds, trust notes, and cancelled checks—none of which contain the claimant's signature. It should be noted that even were his signature present on some of the documents executed since the sale of his home, the significance of such occurrence would have to be weighed in light of the medical doctor's evaluation which describes the claimant as having been severely demented since December 1976.

CONCLUSIONS OF LAW

I

Title 22, CAC, Section 50420 states that the property reserve of a one-person MFBU shall not exceed $1,500.

Title 22, CAC, Section 50403 requires that the separate property and community property share of any person included in the MFBU shall be evaluated in determining Medi-Cal eligibility. Subsection (b)(4) excludes from consideration the separate and share of community property of a person who is not included in the MFBU due to Long-Term Care (LTC) status.

CONCLUSION 1:

Following the sale of the claimant's home in May 1977, his community property share was $32,672.80. This figure is reached as follows:

A. Gross Sales Price:	$75,403.43
B. Less Closing Costs and Pay-Off of Prior Mortgage:	– 10,057.83
C. Community Property Value from Sale of Home (A–B):	$65,345.60
D. Claimant's Community Property Share (½ of C):	$32,672.80

Deducting the $1,500 exemption, the claimant held $31,172.80 in property to be accounted for.

II

Title 22, CAC, Section 50408(a)(2)(A) provides that transfers of property shall not result in ineligibility where the transfer was to satisfy a legal debt.

CONCLUSION 2:

From the $31,172.80 community property share of the proceeds from the sale of his home in May 1977, $13,749.77 must be disregarded as dispersals for the satisfaction of legal debts, leaving $17,423.03 to be accounted for. This conclusions was reached as follows:

EXHIBIT "C"

ALLOWABLE EXPENDITURES
(TO SATISFY LEGAL DEBTS)

	AMOUNT
1. Claimant's own medical expenses (accepted by county)	$ 8,381.88
2. ½ of the personal expenses of the claimant and his spouse that were accepted by the county	2,733.34
3. ½ of expense for common burial plot	984.55
4. ½ of payment to Ernest Orozco for services rendered from August 1976 through April 1977. This expense is accepted by the Hearing Officer as a legal debt based on the following: (a) the claiment's spouse's testimony that Mr. Orozco performed his tasks pursuant to an agreement that he would be paid, (b) the cancelled check showing payment, and (c) the receipt signed by Mr. Orozco indicating the payment was accepted for services he had rendered.	1,650.00
TOTAL:	$13,749.77

III

Title 22, CAC, Section 50406: Transfer or conversion of property may affect eligibility. See Sections 50407 through 50411.

50408. Transfer of Property Which Does Not Result in Ineligibility.

(a) Transfer of property shall not result in ineligibility for Medi-Cal under any of the following conditions:

(1) The net market value of the property transferred, when included in the property reserve, would not result in ineligibility. The determination of value shall be made as of the time of transfer. If eligibility exists, the value of the property shall no longer be considered.

EXHIBIT "C"

(2) Adequate consideration is received. Adequate consideration includes:

(A) A transfer which was to satisfy a legal debt.

(B) A transfer which was to reimburse someone other than a responsible relative, as specified in Section 50351, for care or benefits provided on the basis of an agreement or understanding that reimbursement would be made. The applicant or beneficiary shall provide evidence that clearly establishes that the value of the care or benefits provided was reasonably equivalent to the value of the property transferred.

(3) Foreclosure or repossession of the property was imminent at the time of transfer, and there is no evidence of collusion.

(4) The transfer was made in return for an enforceable contract for life care which does not include complete medical care. In this case, each full item of need provided under the life care contract shall be considered income in kind in accordance with Section 50509.

(b) There is a presumption that property transferred by the applicant or beneficiary more than two years preceding the date of initial application was not transferred to establish eligibility or reduce the share of cost. Such property shall not be considered in determining eligibility, unless there is evidence that conflicts with this presumption.

50409. Transfer of Property Which Results in Ineligibility

(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

EXHIBIT "C"

(1) It shall presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).

(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption.

CONCLUSION 3:

Orange County's denial of the claimant's Medi-Cal application rests on its application of the presumption embodied in Section 50408(b). As it has been already concluded in Sections I and II above that $15,249.77 of his $32,672.80 community property share from the proceeds of the sale of the home have been properly disposed of, the remainder ($17,423.03) is subject to the presumption. Of that amount, $1,630.98 has not been transferred (this is one-half of amount of the funds in checking and savings accounts acknowledged in the record to be unspent as of

April 25, 1978). Thus, $15,792.05 is the outstanding balance that remains unaccounted for.

It is now concluded that that amount ($15,792.05) was not transferred for the purpose of establishing program eligibility. While the Hearing Office does not accept the expenditures submitted by the AR as valid dispositions (payments to claimant's daughter and son-in-law and niece and nephew), the objective facts present in this case are sufficient to conclude that the claimant has overcome the regulatory presumption as required by Title 22, CAC, Section 50409(b)(2). Those objective facts include consideration of the claimant's age (84), health (severe dementia), and life expectancy (short, in light of his age). Perhaps most importantly, though, are the objective facts present in this case which strongly establish that this claimant was without any possible capacity to understand the extent of his resources during the period under review. Given the previous factual finding that since January 1977 he has been unable to transact any legal business, it must be concluded that the transfers which occurred were not done by the claimant for the purpose of establishing program eligibility.

Moreover, this conclusion is further supported by the fact that because of his medical condition the claimant did not even sign the papers required for the sale of his home, much less participate in the subsequent transfers of his property.

Finally, although the transfers from the claimant's community property share of the proceeds from the sale of his home may have been detrimental to the claiment's legal interests, the fact remains that such transfers were not effected by him. Under such circumstances, the county may desire to demand an accounting via its Office of Public Guardian, but the claimant's eligibility for Medi-Cal must be acknowledged. When that is done, the $15,792.05 is disregarded, leaving him with personal property of $1,630.98 in excess of the program limit.

EXHIBIT "C"

IV

Title 22, CAC, Section 50421 provides that program eligibility may be established by spenddown of excess property when the property reserve exceeds the property limit. If the property reserve has been in excess of the property limit from the first day of the month of application through the date of application, and the property reserve is brought within the property limit by the last day of the month of application, the MFBU shall be eligible under the following conditions:

(1) All eligibility requirements except for the property limit shall be met.

(2) The property reserve is brought within the property limit in any manner except by transfer without consideration.

CONCLUSION 4:

As there was no evidence to show that the claimant was advised of the possibility of qualifying by spending down his excess personal property, Orange County must reconsider the April 1978 application.

ORDER

Orange County shall rescind its denial of the claimant's April 12, 1978 Medi-Cal application. If the claimant is then found to be otherwise eligible, the county shall allow him to meet the property limit by spending $1,630.98. In any way other than by transferring without adequate consideration and upon that event, approve his application beginning April 1978 and continuing thereafter.

Further, Orange County shall give the claimant the opportunity to choose between the following alternative remedies for any excessive shares of cost which the beneficiary has paid or obligated himself to pay since that April 1978:

1. Having his current monthly shares of cost reduced in *consecutive* months (beginning with the month immediately following the month in which this decision is implemented by a total amount equal to the total difference between the shares of cost paid or obligated by the beneficiary and the months in which the cost of covered medical services exceeded the correct share of cost; or
2. Having the county (a) issue retroactive Medi-Cal cards for each month in which the beneficiary paid or obligated himself to pay an excessive share of cost; (b) assist the claimant as needed in obtaining the appropriate refunds from the providers of covered services received during such months; and (c) notify the fiscal intermediary that the delayed billings have been authorized by a Fair Hearing Decision adopted by the Director of the Department of Health Services.

EXHIBIT "C"

CALIFORNIA DEPARTMENT
OF HEALTH SERVICES

In the Matter of the Hearing of Claimant
ENOSINSIO MANAHAN
15261 Shallow Lane
Westminister, CA 92683
Fair Hearing No. 78163110 OR
State No. 30-13-315454
District

DECISION OF THE DIRECTOR

Hearing Officer: ERNESTO J. PEREZ
County Representative: JOHN JACOBS
Authorized Representative: TIM FLYNN
Place: Santa Ana, California

Date of Hearing: July 6 & 8, 1978*
Date of County Notice: June 5, 1978
Fair Hearing Filing Date: June 8, 1978
Aid Paid Pending: N/A (Denial Action

ISSUE

The issue for resolution is whether Orange County correctly denied the claimant's April 12, 1978 application for Long-Term Care California Medical Assistance Program (Medi-Cal) benefits because of its determination that he transferred property in order to become eligible.

Based on the evidence presented at the hearing, the referee prepared a proposed decision. The Director of the

* Record left open until July 28, 1978 for the claimant to submit additional documents. Such information was received, and the record was closed on August 15, 1978. The county did not submit rebuttal evidence.

EXHIBIT "D"

State Department of Health Services, being disatisfied with the decision, herein adopts the Statement of Fact together with an amended Conclusion of Law and Order as follows:

STATEMENT OF FACT

The referee's Statement of Fact is incorporated herein by this reference.

FINDINGS OF FACT

The referee's Findings of Fact is incorporated herein by this reference.

CONCLUSIONS OF LAW

The referee's Conclusions of Laws I and II are incorporated herein by this reference.

III

Title 22, CAC, Section 50406: Transfer or conversion of property may affect eligibility. See Sections 50407 through 50411.

50408. Transfer of Property Which Does Not Result in Ineligibility.

(a) Transfer of property shall not result in ineligibility for Medi-Cal under any of the following conditions:

(1) The net market value of the property transferred, when included in the property reserve, would not result in ineligibility. The determination of value shall be made as of the time of transfer. If eligibility exists, the value of the property shall no longer be considered.

(2) Adequate consideration is received. Adequate consideration includes:

(A) A transfer which was to satisfy a legal debt.

(B) A transfer which was to reimburse someone other than a responsible relative, as specified in Section 50351, for care or benefits provided on the basis of an agreement or understanding that reimbursement would be made. The applicant or beneficiary shall provide evidence that clearly establishes that the value of the care or benefits provided was reasonably equivalent to the value of the property transferred.

(3) Foreclosure or repossession of the property was imminent at the time of transfer, and there is no evidence of collusion.

(4) The transfer was made in return for an enforceable contract for life care which does not include complete medical care. In this case, each full item of need provided under the life care contract shall be considered income in kind in accordance with Section 50509.

(b) There is a presumption that property transferred by the applicant or beneficiary more than two years preceding the date of initial application was not transferred to establish eligibility or reduce the share of cost. Such property shall not be considered in determining eligibliity, unless there is evidence that conflicts with this presumption.

50409. Transfer of Property Which Results in Ineligibility

(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

(1) It shall presume that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).

EXHIBIT "D"

(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption.

CONCLUSION 3:

Orange County's denial of the claimant's Medi-Cal application rests on its application of the presumption embodied in Section 50409(b). As it has been already concluded in Sections I and II above that $15,249.77 of his $32,672.80 community property share from the proceeds of the sale of the home have been properly disposed of, the remainder ($17,423.03) is subject to the presumption. Of that amount, $1,630.98 has not been transferred (this is one-half of amount of the funds in checking and savings accounts acknowledged in the record to be unspent as of April 25, 1978). Thus, $15,792.15 is the outstanding balance that remains unaccounted for.

It is concluded that the claimant has not overcome the presumption that the transfer of property was for the purpose of establishing eligibility. In accordance with Section

50409(b), this presumption may only be overcome by the claimant providing evidence that adequate resources were available at the time of the transfer to provide for the claimant for the remainder of his life. The transfer of property occurred some time after May 1977. The claimant had been in a nursing home since January 1977 and was in continuing need of extensive support and medical care. Evidence was not provided to show that adequate resources were available at the time of the transfer to care for the claimant for the remainder of his life. The fact that the claimant's spouse, having power of attorney and acting on behalf of the claiment, made the transfer of property does not absolve the claimant of this action. Although the claimant was incompetent, a competent person, his wife acted in his behalf.

ORDER

The claim is denied.

The foregoing is the Decision and Order of the Director, State Department of Health Services, in the above-entitled matter.

1-12-79 /s/ Elizabeth H. Lyman

(Date)

EXHIBIT "D"

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. 78-2350 MML(Sx)

ROSSYE DAWSON, individually and on behalf of all others similarly situationed, PLAINTIFF,

v.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, individually and on behalf of all other similarly situated, INTERVENOR-PLAINTIFF.

ANSWER TO COMPLAINT IN INTERVENTION FOR DECLARATORY AND INJUNCTIVE RELIEF FILED MARCH 19, 1979

CLASS ACTION

COME NOW defendants Beverlee A. Myers, successor to Edwin W. Beach, herein erroneously sued as Edward Beach, individually and in her official capacity as Director of the California State Department of Health Services, successor to the State Department of Health, and Elisabeth Lyman, successor to Bruce Yarwood, individually and in her official capacity as Acting Chief Deputy Director of the Medical Care Services and Deputy Director of Medical Care Standards Division of the State Department of Health Services, successor to the State Department of Health, and each of them, and answer the complaint for declaratory and injunctive relief as follows:

1. Answering paragraph 1 of the complaint, defendants deny that the State of California is improperly applying

eligibility requirements which do not comport with federal law.

2. Answering paragraph 2 of the complaint, defendants deny that there is in excess of $10,000 in controversy and admit the remaining allegations of paragraph 2.

3–4. Defendants deny for lack of sufficient information or belief each and every allegation contained in paragraphs 3 and 4 of the complaint.

5. Defendants deny that Edward Beach is the former Director of Department of Health Services and affirmatively allege that Edwin Beach is the former Director of the Department of Health, predecessor to the Department of Health Services.

6. Answering paragraph 6 of the complaint, defendants deny that Bruce Yarwood is the Deputy Director of the State Department of Health Services and affirmatively allege that Elisabeth Lyman, successor to Bruce Yarwood, is the acting Chief Deputy Director of Medical Care Services and Deputy Director of Medical Care Standards Division of the Department of Health Services.

7. Answering paragraph 7 of the complaint, defendants admit that intervenors Beltran and Manahan bring this action on their own behalf and deny each and every remaining allegation contained in said paragraph 7.

8. Answering paragraph 8 of the complaint, defendants deny that state Medicaid programs are controlled solely by federal regulations. In connection therewith, defendants affirmatively allege that pursuant to the State Medicaid plan, the state enters into contracts to fulfill the particular federal options for coverage which it chooses to apply. State Medicaid programs are also controlled by state statutes and regulations.

9. Defendants admit the allegation contained in paragraph 9.

10. Answering paragraph 10 of the complaint, defendants deny that income is the only Medicaid eligibility guideline for the aged, blind, and disabled.

11. Defendants admit the allegations contained in paragraph 11 of the complaint. Defendants affirmatively allege

that Supplemental Security Income (SSI) recipients are eligible for Medicaid benefits if the State Plan so provides.

12. Defendants admit the allegations contained in paragraph 12 of the complaint.

13. Defendants deny each and every allegation contained in paragraph 13 of the complaint.

14. Answering paragraph 14 of the complaint, defendants deny the existence of a rule stating that the provision of health care will not be restricted by property holdings. Defendants admit that the quote contained in said paragraph 14 is a portion of Welfare and Institutions Code section 14015.

15. Defendants admit the allegations contained in paragraph 15 of the complaint.

16. Except as otherwise provided by 22 California Administrative Code section 50411(a), defendants admit the allegations contained in paragraph 16 of the complaint.

17. Defendants deny for lack of sufficient information and belief, each and every allegation contained in paragraph 17.

18. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 18. Defendants admit that Mr. and Mrs. Beltran were found eligible for Medi-Cal in May 1977. Defendants affirmatively allege that Mr. and Mrs. Beltran were found eligible under the In Home Supportive Services Program which was not then, but is now the medically needy program.

19. Defendants deny each and every allegation contained in paragraph 19 of the complaint.

20. Defendants admit the allegations contained in paragraph 20 of the complaint. Defendants affirmatively allege that a copy of only the front side of the Notice of Action is attached to the complaint as Exhibit A.

21. Except as otherwise provided by the Notice of Action defendants admit the allegations contained in paragraph 21 of the complaint.

22. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 22 of the complaint.

23. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 23 of the complaint. Defendants admit that Mr. Manahan entered the convalescent home in January 1977.

24. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 24. Defendants admit that on April 12, 1978, the application for Medi-Cal was made on Enosinsio Manahan's behalf by Mrs. Lucille Tom at the Orange County Department of Social Services.

25. Defendants admit the allegations contained in paragraph 25 of the complaint. Defendants affirmatively allege that only the front side of Exhibit B is attached to the complaint.

26. Defendants admit the allegations contained in paragraph 26 of the complaint.

27. Defendants admit the allegations contained in paragraph 27 of the complaint. Defendants affirmatively allege that page 12, signature page, form no. DPA 320 (8–76) is missing from Exhibit C.

28. Defendants deny each and every allegation contained in paragraph 28 of the complaint. Defendants admit that on January 12, 1979, the director of the State Department of Health Services alternated the decision of the hearing officer and a copy of the decision of the director is attached as Exhibit D to the complaint.

29. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 29.

30–31. Defendants deny each and every allegation contained in paragraphs 30 and 31.

FIRST CAUSE OF ACTION

32–33. Defendants deny each and every allegation contained in paragraphs 32 and 33. Defendants affirmatively

allege that California is providing Medi-Cal benefits automatically to all persons receiving SSI benefits and that the SSI program does not predicate eligibility on a transfer of assets for adequate consideration prior to application if the transfer is bona fide and irrevocable.

34–35. Defendants admit the allegations contained in paragraphs 34 and 35. Defendants affirmatively allege that 42 Code of Federal Procedure section 448.3(c)(1)(iv) and its successor regulation provide an alternative by which the states may impose a more stringent criteria.

36. Defendants deny each and every allegation contained in paragraph 36 of the complaint.

SECOND CAUSE OF ACTION

37. Defendants deny each and every allegation contained in paragraph 37 of the complaint.

THIRD CAUSE OF ACTION

38. Defendants deny each and every allegation contained in paragraph 38 of the complaint.

FOURTH CAUSE OF ACTION

39. Defendants deny each and every allegation contained in paragraph 39 of the complaint.

FIFTH CAUSE OF ACTION

40. Defendants deny each and every allegation contained in paragraph 40 of the complaint.

FIRST AFFIRMATIVE DEFENSE

1. The Court should dismiss the complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief could be granted on the ground that the plaintiffs have failed to exhaust their available administrative remedies provided by California Government Code section 11426.

SECOND AFFIRMATIVE DEFENSE

2. The Court should dismiss the complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief can be granted, on the ground that the exclusive remedy for judicial review of adjudicatory administrative action is to file a petition for writ of mandate in the state court pursuant to California Code of Civil Procedure section 1094.5.

THIRD AFFIRMATIVE DEFENSE

3. The Court should dismiss the complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief could be granted on the ground that plaintiff Antonia Beltran has failed to exhaust her available administrative remedy provided by Welfare and Institutions Code sections 10950–10963, 14001; Title 22 California Administrative Code sections 50951–50955.

FOURTH AFFIRMATIVE DEFENSE

4. The Court should dismiss the complaint for failure to state a claim upon which relief could be granted on the ground that one or more of the plaintiffs lack the mental and/or physical capacity to sue. On or about October 12, 1978, defendants are informed and believe that plaintiff Rossye Dawson died.

FIFTH AFFIRMATIVE DEFENSE

5. The Court should dismiss the complaint for lack of jurisdiction over the subject matter because the amount in controversy is less than ten thousand dollars, exclusive of interests and costs, in that if any one or more of the plaintiffs have any claim against defendants, such claims constitute separate claims of the particular plaintiffs so damaged, none of which separately equals or exceeds ten thousand dollars, exclusive of interests and costs, and such claims, cannot be aggregated for purposes of the amount in controversy requirement.

SIXTH AFFIRMATIVE DEFENSE

6. The complaint fails to state a claim against defendants upon which relief can be granted.

WHEREFORE, defendants deny that the plantiffs are entitled to the relief prayed for in the complaint, or any relief whatsoever against defendants, and defendants respectfully pray that the complaint be dismissed with costs and disbursements to the defendants.

DATED: March 19, 1979.

GEORGE DEUKMEJIAN, Attorney General
ANNE S. PRESSMAN,
DONALD A. ROBINSON,
RICHARD J. MAGASIN, Deputy Attorneys General

By _____
DONALD A. ROBINSON

By _____
RICHARD J. AGASIN
Attorneys for Defendants

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. CV-78-2350-MML

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF,

v.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, individually and on behalf of all others similarly situated, INTERVENOR-PLAINTIFF,

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ORDER GRANTING PLAINTIFFS' MOTION FOR CERTIFICATION OF THE CLASS FILED MAY 10, 1979

The Court having considered plaintiffs' motion for an order certifying this case as a class action pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, and the Court having considered memoranda and arguments of the parties, it is determined that this action meets the requirements of Rule 23(a) in that:

(1) Joinder of all members of the class would be impracticable since their number, though unknown, is great (the defendants having stipulated to numerosity); they are dispersed throughout the State of California and by definition they are aged, blind and disabled and, therefore, would be incapable of participating in this action as individual plaintiffs;

(2) There are questions of law and fact common to each member of the class. The common question of fact is that each has been denied Medi-Cal benefits because of the de-

fendants' application of a transfer of assets rule to them. The common question of law is the propriety of the application of the transfer of assets rule;

(3) The claims of the plaintiffs are typical of the claims of each class member, as each of the named plaintiffs has been denied Medi-Cal as a result of the application of the transfer of assets rule;

(4) Plaintiffs will fairly and adequately protect the interests of the class. They are represented by able counsel, who are experienced in class action litigation.

Furthermore, this action also meets the requirements of Rule 23(b)(2) in that the defendants have acted on grounds generally applicable to the class, and final injunctive and declaratory relief with respect to the class as a whole is appropriate.

IT IS THEREFORE ORDERED that this action shall be maintained as a class action, the class to consist of all aged, blind and disabled individuals who, as of June 19, 1978, have been or are denied Medi-Cal benefits because of an alleged transfer of assets for inadequate consideration pursuant to Welf. & Inst. C. § 14015 and 22 Cal.Adm. Code § 50409.

Dated: May 9, 1979

/s/ _____

MALCOLM M. LUCAS
United States District Judge

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. CV-78-2350-MML

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF

v.

EDWARD BEACH, ET AL., DEFENDANTS

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, individually and on behalf of all others similarly situated, INTERVENOR-PLAINTIFF,

---

FINDINGS OF FACT AND CONCLUSIONS OF LAW FILED MAY 10, 1979

This cause came on for hearing on defendants' Motion for Summary Judgment and plaintiffs' Cross-Motion for Summary Judgment, and the Court, having considered the memoranda of points and authorities filed by the parties in support of such motions and the documents and exhibits thereto, and the stipulation of the parties, and having heard oral argument by the parties in support of such motions, finds the facts and states the conclusion of law as follows:

FINDINGS OF FACT

1. With respect to Rossye Dawson.

a. On February 18, 1977, an application for Medi-Cal was filed on behalf of Rossye Dawson;

b. The County of Riverside Department of Public Social Services approved the application pending a property verification;

c. On May 17, 1977, the County of Riverside Department of Public Social Services sent a Notice of Action letter to Rossye Dawson determining that she was no longer eligible for Medical-Cal because she had transferred property without adequate consideration in violation of Title 22, California Administrative Code section 50409;

d. Rossye Dawson filed a request for a fair hearing, which was held on September 14, 1977;

e. The hearing officer found that the transfer of property for inadequate consideration was in May 1977, that Rossye Dawson had failed to overcome the presumption that the transfer was made for the purpose of qualifying for Medi-Cal, and that therefore her claim for Medi-Cal benefits should be denied;

f. The proposed decision of the hearing officer was adopted by the Director of the State Department of Health on February 15, 1978;

g. Rossye Dawson has never sought judicial review of the director's decision by filing a petition for writ of mandate pursuant to section 1094.5 of the California Code of Civil Procedure; and

h. On or about October 30, 1978, counsel for Rossye Dawson filed a "Certificate of Counsel re Death of Plaintiff." No substitution for the deceased plaintiff has been made.

2. With respect to intervenor Enosinsio Manahan:

a. On April 12, 1978, an application for Medi-Cal was filed on behalf of Mr. Manahan;

b. The Orange County Department of Social Services denied his application on the ground that he had transferred property in order to be eligible for Medi-Cal in violation of, *inter alia*, Title 22 California Administrative Code section 50409;

c. A fair hearing was requested and held on July 6 and 7, 1978 on the county's denial of Medi-Cal;

d. The hearing officer found that Mr. Manahan had overcome the presumption that the transfer of property was for the purpose of qualifying for Medi-Cal. The hear-

ing officer recommended that he be eligible for Medi-Cal once he met the Medi-Cal property limit spend-down.

e. On January 12, 1978, the Director of the State Department of Health Services reversed the proposed decision of the hearing officer. The director found that Mr. Manahan had not overcome the presumption; and

f. He has not sought judicial review of the director's decision by filing a petition for writ of mandate in the state court pursuant to California Code of Civil Procedure section 1094.5.

3. With respect to intervenor Antonia Beltran:

a. On October 27, 1978, she re-applied for Medical benefits;

b. The Notice of Action dated January 8, 1979 indicated that the denial of Medi-Cal eligibility was based on a transfer of property in 1977.

c. She did not request a fair hearing from the determination of the county, and no fair hearing was held.

4. Except for the application of the transfer of assets rule to these three individuals, they would be eligible for Medi-Cal coverage under the state's medically needy program.

5. Defendant Beverlee A. Myers, successor to Edwin W. Beach, is the Director of the California State Department of Health Services, successor to the State Department of Health.

6. Defendant Elisabeth Lyman, successor to Bruce Yarwood, is the Acting Chief Deputy Director of the Medical Care Services and Medical Care Standards Division of the State Department of Health Services.

7. To the extent that any of the following conclusions of law are deemed findings of fact, the same are incorporated herein by reference.

CONCLUSIONS OF LAW

1. The Court has jurisdiction over this case pursuant to 28 U.S.C. § 1343(3), (4), as this is an action authorized by

42 U.S.C. § 1383 to redress the deprivation of rights under color of state law. The Court has pendent jurisdiction over any claims not specifically authorized pursuant to 42 U.S.C. § 1983. Jurisdiction is also conferred by 28 U.S.C. § 1331, as there is more than $10,000.00 in controversy. This case has been certified as a class action.

2. Rossye Dawson lacks capacity to sue as she is deceased and no substitution has been made for her pursuant to Federal Rules of Civil Procedure section 25(a)(1).

3. The federal Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is a system of cooperative federalism in which the states and other jurisdictions have the option to participate, and to receive partial reimbursement for services provided. If they decide to participate, the states are required to operate their Medicaid Program within the contours of the federal statute and regulations, and to submit a state plan to the Secretary of the Department of Health, Education, and Welfare that comports with controlling federal laws. In order to be eligible for reimbursement, the states which decide to participate must comply with the mandatory requirements established by the Social Security Act as interpreted and implemented by HEW. *Townsend* v. *Swank*, 404 U.S. 282, 286 (1971); *King* v. *Smith*, 392 U.S. 309, 333 (1968); *County of Alameda* v. *Carleson*, 5 Cal.3d 730, 739 (1971); *Wong* v. *Brian*, CCH Medicare & Medicaid Guide, [1974] Transfer Binder, ¶ 26, 605 (Cal.Ct. App. 1972).

4. Once a state decides to participate, it must provide Medicaid benefits to the "categorically needy", who are individuals meeting both the categorical requirements of being aged, blind, or disabled, and also the financial eligibility requirements. 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. § 435.120; see *Friedman* v. *Berger*, 547 F.2d 724, 726 (2d Cir. 1976), *cert. denied* 430 U.S. 984 (1977); *Wong* v. *Brian*, *supra*, ¶ 26, 605 at 9013.

5. In addition, states have the option of providing Medicaid assistance to the so-called "medically needy" who are individuals meeting the categorical requirements of being aged, blind or disabled, but who have incomes or

resources above the financial requirements. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 435.300 *et seq.*, see *Friedman* v. *Berger, supra; Wong* v. *Brian, supra.*

6. California has opted to participate in the Medicaid Program, and has further opted to provide assistance to the medically needy. 22 Cal.Adm. Code § 60249(a)(1); *Wong* v. *Brian, supra.*

7. The general rule is that recipients of Supplemental Security Income ("SSI"), who are aged, blind, or disabled individuals receiving federal cash benefits, are categorically needy and are therefore automatically eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A). California, as well as other states, has been given the option by Congress of using a different eligibility test for the categorically needy than that they be recipients of SSI. Under this test, a state can use more restrictive financial eligibility conditions than those set out in the SSI program, but no more restrictive than those in effect in the state on January 1, 1972. 42 U.S.C. § 1396a(f); 42 C.F.R. § 431.121; see *Hayes* v. *Stanton*, 512 F.2d 133, 137-138 (7th Cir. 1975); *West* v. *Cole*, 390 F.Supp. 91, 95-96 (N.D. Miss. 1975); *Gray Panthers* v. *Secretary, Department of Health, Education and Welfare*, 461 F.Supp. 319, 321 (D.D.C. 1978).

8. In its Medicaid Program, known in this state as Medi-Cal, California has not selected this option, and therefore must provide, and does provide, automatic categorical assistance to all recipients of SSI. Cal. Adm. Code § 50227.

9. The federal Medicaid statute requires those states which provide medically needy benefits to include as eligible "all individuals who would, except for income and resources, be eligible to have paid with respect to them Supplemental Security Income benefits . . . ." 42 U.S.C. § 1396a (a)(10)(C)(i).

10. A state may not impose conditions of eligibility on the medically needy that are more restrictive than those imposed on the categorically needy, that is, recipients of SSI. 42 C.F.R. § 435.401(c). Of course, a state may impose

collateral restrictions on the medically needy that are not imposed on the categorically needy. 42 U.S.C. § 1396a (a)(17)(A); 45 CFR § 233.10(a)(1)(ii)(B).

11. Cal.Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 are designed to eliminate fraudulent practices affecting eligiblity for benefits. The federal statute is concerned with substantive eligibilty requirements only, and does not place any specific restrictions on the state's right to police fraud. Consequently, the transfer of assets rule is a procedural regulation which is not prohibited by 42 USC § 1396a(a)(10)(C)(i).

12. Cal.Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 do not violate 42 U.S.C. § 1396a(a)(17)(B) or 42 CFR § 435.845. The purpose of these state law provisions is to deter transfers of assets solely for the purpose of qualification. To the extent an asset is transferred for the purpose of qualifying for benefits, the asset should be treated as being available for the applicant's use.

13. Cal.Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 are not in conflict with any federal law or regulation governing the Medicaid/Medi-Cal program. They do not violate the Supremacy Clause of the United States Constitution.

14. Cal. Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 do not establish an irrebutable presumption that a transfer of assets was made with the intent of gaining eligibility and so do not violate the due process clause of the Fourteenth Amendment to the United States Constitution.

15. A rational distinction between SSI recipients and the medically needy is made in Cal. Welf. & Inst. Code § 14015 and 22 Cal. Adm. Code § 50409. The state has an interest in assuring that medical assistance benefits are dispersed only to those who are truly in need. Those receiving SSI by definition are in financial need. It is rational for the state to scrutinize transfers of assets by the medically needy to assure that financial eligibility is not improperly manufactured. The Court therefore holds that the equal protection clause of the Fourteenth Amendment

has not been violated by Cal.Welf. & Inst. Code § 14015 and 22 Cal. Adm. Code § 50409.

16. To the extent that any of the foregoing findings of fact are deemed conclusions of law, the same are incorporated herein by reference.

17. The plaintiff's motion for summary judgment is denied, and the defendants' motion for summary judgment is granted. Judgement shall be entered accordingly.

Dated: May 10, 1979

/s/ _____

MALCOLM M. LUCAS
United States District Judge

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

NO. 78-2350 MML(Sx)

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF,

v.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, Individually and on behalf of all other similarly situated, INTERVENOR-PLAINTIFF,

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SUMMARY JUDGMENT
ENTERED MAY 10, 1979

This cause came on to be heard on motion of the defendants for summary judgment and on cross-motion of the plaintiffs and intervenor plaintiffs for summary judgment, pursuant to Rule 56 of the Federal Rules of Civil Procedure, and the court having considered all papers, and the court having heard the argument of counsel, and due deliberation having been had thereon, it is

ORDERED, that plaintiffs' cross-motion for summary judgment be the same hereby is denied, and it is further

ORDERED, that defendants' motion for summary judgment be and the same hereby is granted, and it is further

ORDERED, ADJUDGED AND DECREED that the action be dismissed on its merits, and that each side bear own costs of suit.

DATED: 5/19/79.

/s/ _____

MALCOLM M. LUCAS
United States District Judge

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 79-3246

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF-APPELLANT,

v.

BEVERLEE A. MYERS,* ET AL., DEFENDANTS-APPELLEES.

On Appeal from the United States District Court
for the Central District of California
The Honorable Malcolm M. Lucas, Presiding

OPINION—FILED MAY 14, 1980
D.C. No. C 78-2350 MML

Before: WRIGHT and ANDERSON, *Circuit Judges*, and SOLOMON, ** *District Judge*.

J. BLAINE ANDERSON, *Circuit Judge:*

This is a class action challenging the State of California's transfer of assets rule which was relied upon to deny Medi-Cal benefits to members of the class. In short, this rule denies Medi-Cal benefits to any individual who has transferred assets so as to qualify under the financial eli-

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*Beverlee A. Myers, the Director of the California State Department of Health Services, is the successor to Edwin W. Beach, the originally named defendant. Since Myers succeeded Beach prior to when this appeal was taken, we make the substitution under Fed. R. Civ. P. 25(d)(1) rather than Fed. R. App. P. 43(c)(1).

**The Honorable Gus J. Solomon, Senior United States District Judge for the District of Oregon, sitting by designation.

gibility requirements for Medi-Cal. The class members argue that the transfer rule conflicts with the federal Medicaid statutes and regulations, and they also challenge the rule's constitutionality based on due process and equal protection grounds. The court below rejected all of these arguments and upheld the transfer rule. We believe that the district court reached the correct result and affirm.

I. Background

A. *Medicaid*

Title XIX of the Social Security Act established the Medicaid program. 42 U.S.C. § 1396 *et seq*. This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. § 1396(b). Despite the extensive federal standards (42 U.S.C. § 1396a), the individual states are given wide discretion in the administration of their local programs. *Norman v. St. Clair*, 610 F.2d 1228, 1230 (5th Cir. 1980). After a state's plan is approved by the Secretary of Health, Education and Welfare, the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. § 1396.

A state which has chosen to adopt a Medicaid program has the option of deciding whether it should provide benefits to only one or to both of the statutorily-defined groups of needy persons. States participating in the program *must* provide assistance to the group which is referred to as the *categorically needy*.[1] 42 U.S.C. § 1396a(10)(A). Generally, in order to be considered *categorically needy*,

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[1] The regulations define this group as follows:

> Categorically needy" means aged, blind or disabled individuals or families and children who are otherwise eligible for medicaid and who meet the financial eligibility requirements for AFDC, SSI, or an optional State supplement;"

42 C.F.R. § 435.4.

an individual must be receiving financial assistance, or be financially eligible for such assistance, under Title IV–A of the Social Security Act (Aid to Families with Dependent Children, referred to as AFDC) or Title XVI of the Social Security Act (Supplemental Security Income for the Aged, Blind, and Disabled, referred to as SSI).[2]

When they establish their Medicaid program, the states have the option of also providing benefits to the group which is referred to as the *medically needy*. This group covers individuals who would qualify for AFDC or SSI except that they have sufficient income and resources to cover the essentials aside from their medical costs.[3] The *medically needy* begin receiving assistance after they have incurred medical expenses which reduce their income (and assets) below a prescribed level. Thus, the chief distinction between the two groups is that the *categorically needy* have lower incomes and less resources than the *medically needy*.

B. *Medi-Cal*

California, through its Medi-Cal program, has voluntarily chosen to participate in the Medicaid program. In addition, California voluntarily chose to cover the *medically needy* as well as the *categorically needy*. California has adopted a comprehensive statutory and regulatory scheme to implement its Medi-Cal program.

As part of its plan, the California legislature adopted what is called a transfer of assets rule. Cal. (Welf. & Inst.)

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[2] States have the option of using more restrictive criteria than those used under the AFDC or SSI programs. California has not chosen this option and so this opinion does not deal with those provisions of the Medicaid Act which would then come into play.

[3] The regulations define this group as follows:

> "Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for medicaid and whose income and resources are above the limits set under the medicaid State plan;"

43 C.F.R. § 435.4.

Code § 14015.[4] Basically, this prevents persons from qualifying as *medically needy* if they have transferred assets for less than fair consideration within two years prior to their application for assistance. The transfer rule only applies to applicants in the *medically needy* group; it has no application at all to the *categorically needy*.

California has promulgated regulations which, among other things, establish eligibility requirements for the *medically needy* and implement the transfer rule.[5] Under

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[4] The statutory part of the transfer rule provides as follows:

> "The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director, and in no event for less than half of the period that the capital value of the transferred property would have supplied the person's maintenance needs based on his circumstances at the time of his transfer plus the cost of any needed medical care."

Cal. (Welf. & Inst.) Code § 14015.

[5] The transfer rule is implemented, for the most part, through 22 Cal. Admin. Code §§ 50408, 50409. The first section (§ 50408) states the general conditions for when the transfer of property will not result in ineligibility. The rule and the procedure for overcoming the presumption are then stated in § 50409:

> "(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet at least one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.
>
> "(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.
>
> "(1) It shall be presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).
>
> "(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts,

these regulations, an individual is eligible as *medically needy* only if his or her assets are valued at $1500 or less. 22 Cal. Admin. Code § 50420. An individual's home, income-producing real property, and certain other assets are not counted toward the $1500 limitation. 22 Cal. Admin. Code §§ 50418, 50425–50489. Although this property is exempt insofar as determining eligibility, it remains potentially subject to California's recovery procedures. That is, after the individual dies, California is entitled to recover the cost of medical assistance it provided to the individual from the assets (including both exempt and nonexempt property) which are left in the individual's estate.

Under the regulations which implement the transfer rule, any transfer of assets (including exempt property) for less than adequate consideration creates a rebuttable presumption that the transfer was made for the purpose of establishing eligibility. Unless the applicant rebuts the presumption, the state can deny benefits on this basis.

C. *Facts*

Dawson, who originally filed this action, has died. Two other individuals, Beltran and Manahan, intervened. Bel-

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rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

"(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

"(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption."

tran, who is 87, lives in an extended care facility. Manahan, who is 85, lives in a convalescent home. Both Beltran and Manahan were *medically needy* and otherwise qualified to receive Medi-Cal benefits. However, both were denied benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. Neither was able to overcome the presumption of ineligibility resulting from these transfers.

In their complaint, Beltran and Manahan (referred to as appellants), on behalf of themselves and others similarly situated, sought declaratory and injunctive relief invalidating and enjoining the California transfer rule. In addition, the appellants sought reimbursement for those amounts which they had been forced to pay because of the state's transfer rule. The district court certified a class consisting of all those who had been denied Medi-Cal benefits based on California's transfer rule.

On May 10, 1979, the district court granted California's motion for summary judgment and denied the cross motion filed by the appellants. The court entered findings of fact and conclusions of law which held that the state's transfer rule did not conflict with the federal statutory and regulatory framework, nor did it amount to a denial of due process or equal protection. The appellants then brought this appeal.[6]

II. Discussion

The appellants make five distinct arguments against California's transfer rule. They claim that it creates an ir-

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[6] The district court concluded that it has jurisdiction under 28 U.S.C. § 1343(3) & (4) (civil rights jurisdiction) and under 28 U.S.C. §1331 (federal question jurisdiction). It is unclear whether jurisdiction was properly invoked under 28 U.S. § 1343. *See Chapman v. Houston Welfare Rights Orig.*, 441 U.S. 600, 99 S.Ct. 1905, 60 L.Ed. 2d 508 (1979); *Doe v. Klein*, 559 F.2d 338 (9th Cir. 1979). Nevertheless, the amount in controversy exceeds $10,000 and so the district court did clearly have federal question jurisdiction (28 U.S.C. § 1331). *Brown v. Stanton*, F.2d No. 79-1459, slip op. 2 n.1 (7th Cir. 1980); *see Chapman, supra*, 60 L.Ed.2d at 515. Since the appellants filed a timely notice of appeal from the final judgement, this court has jurisdiction to consider the appeal under 28 U.S.C. § 1291.

rebuttable presumption in violation of the due process clause. Since the rule only applies to the *medically needy*, they contend that it also violates the equal protection clause. Furthermore, the appellants claim that the transfer rule conflicts with two different sections of the federal statutes (42 U.S.C. § 1346a(a)(10)(C), 1396a(a)(17)(B), as well as one section of the federal regulations (42 C.F.R. § 435.401). We address the challenges based on the federal statutes and regulations first because if the appellants' arguments are correct, we would not need to reach the constitutional issues. *Dandridge v. Williams*, 397 U.S. 471, 475–476, 25 L.Ed.2d 491, 90 S.Ct. 1153 (1970). Moreover, in addressing appellants' arguments, the cardinal principle of statutory construction must be kept in mind, that is, statutes should be construed to avoid constitutional questions. *See Swain v. Pressley*, 430 U.S. 372, 378 n.11, 97 S.Ct. 1224, 51 L.Ed.2d 411 (1977)

A. *42 U.S.C. § 1396a(a)(10)(C)*

Appellants' primary argument is that the California transfer rule conflicts with 42 U.S.C. § 1396a (a)(10)(C), which requires states providing benefits to the *medically needy* to cover "all individuals who would, except for income and resources" be eligible for SSI (and therefore come under the *categorically needy* classification), "and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services."[7] The appellants attribute the following meaning to

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[7] This statute provides, in part, as follows:

"A state plan for medical assistance must —provide—

"(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

"(i) *for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to*

§ 1396(a)(10)(C): "except for the definitional distinction that the medically needy may have higher income and resource levels, the states must use the same rules for the medically needy as for the categorically needy."

Under the Social Security Act, an SSI applicant whose assets exceed the eligibility levels may dispose of the excess assets in order to become eligible for SSI payments. 42 U.S.C. § 1382b(b). This has been administratively interpreted to permit the transfer of the excess assets for less than adequate consideration or as a gift. Social Security Claims Manual § 12507(a). According to the appellants, since transfer rules cannot be applied to SSI applicants (i.e., the *categorically needy*), they therefore cannot be applied to the *medically needy*.

The court below rejected the appellants' reasoning and concluded that the California transfer rule did not conflict with § 1396a(a)(10)(C). The court agreed with the appellants that California could not employ any substantive eligibility requirements on the *medically needy* which were more restrictive than those used for the *categorically needy*. Nevertheless, the court characterized the transfer rule as a collateral or procedural eligibility requirement which was permissible under the Social Security Act. While we agree with the district court that the California transfer rule does not conflict with § 1396a(a)(10)(C), we do not accept the semantic distinction which was relied upon.

We believe that the California transfer rule is properly characterized as a substantive eligiblity requirement. It

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have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs and services, and

"(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

***(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a) (10).

directly applies to the state's determination of whether an applicant's assets exceed the eligibility requirements.

In considering the appellant's argument, we must first turn to the language of the statute itself. Obviously, the face of this statute says nothing about prohibiting transfer rules such as California's.[8]

The portion of the statute with which we are concerned may be divided into two parts. The first part provides that the medically needy group includes all who would, except for their income and resources, be eligible for SSI. The second part provides that the medically needy group includes all who have insufficient income and resources, as determined under comparable standards, to pay for their medical care.

The first part specifically excepts income and resources when it equates SSI eligibility to the *medically needy* eligibility requirements. And so, while this provision does extend all of the SSI eligibility requirements to the *medically needy*, it does not do so for those which deal with the applicant's income and resources. Were this not the case, then there would be no distinction between the two groups. There can be no question but that the California transfer rule is an eligibility requirement which pertains to the applicant's income and resources. It therefore clearly comes within the exception to the first clause of the statute.

The second part may be read as requiring that the evaluation of the applicant's income and resources be de-

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[8] At one point, appellants suggest that states can only use requirements which are explicitly authorized by the federal statute. We were unable to find any provision of the statute which said this. In the absence of some expression by Congress to the contrary, we decline to read such a prohibition into a statute which is, after all, establishing a *cooperative* federal state program. *See, New York Department of Social Services v. Dublino*, 413 U.S. 405, 93 S.Ct. 2507, 37 L.Ed.2d 688 (1973) ("It will not be presumed that a federal statute was intended to supersede the exercise of the power of the state unless there is a clear manifestation of an intention to do so." 413 U.S. at 413, *quoting Schwartz v. Texas*, 344 U.S. 199, 202–203, 73 S.Ct. 232, 97 L.Ed. 231 (1952)).

termined by using comparable standards. Since an SSI applicant is apparently specifically allowed to transfer assets in the manner in which is prohibited by the California transfer rule, we are faced with an inconsistent standard. Nevertheless, this does not make the California rule necessarily in conflict with this part of the statute. After all, the statute only requires the standards to be comparable, not identical. Comparable only means that there must be enough similar characteristics or qualities to make comparison appropriate. Webster's Third New International Dictionary, G.& C. Merriam Co. (1976). The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the *medically needy* group (including the transfer rule) are not comparable to those which are used under the SSI program.

In support of their argument, the appellants claim that HEW, the agency charged with administering the Medicaid program, has interpreted § 1396a(a)(10)(C) in the same manner as they would have this court. Apparently, three different HEW Regional Medical Directors have written letters stating that state transfer rules are inconsistent with § 1396a(a)(10)(C) because they impose more restrictive eligibility requirements on the *medically needy* than on SSI applicants. *See Fabula* v. *Buck*, 598 F.2d 869, 873 (4th Cir. 1979). Although this court generally defers to an administrative agency's interpretation of the law which it is charged with administering, we are by no means bound by the agency's interpretation. *Pacific Coast Medical Enterprises* v. *Harris*, F.2d, slip op. 2516, 2525–2526 (9th Cir., March 28, 1980); *Baker* v. *United States*, 613 F.2d 224, 226–227 (9th Cir. 1980).

In the present case, we not only refuse to follow the letter interpretations, but we also refuse to attach any weight to them. Initially, we are convinced that our interpretation of § 1396a(a)(10)(C) is correct, that is, the California transfer rule does not conflict with the statute. This court's "deference does not extend to agencies' construction which conflict with statutory directives." *Pacific*

Coast, *supra*, slip op. at 2526. While regional administrators may be writing letters disapproving of state transfer rules, HEW as a whole has approved California's Medi-Cal program (and the transfer rule). By this approval, and by not taking any action against California because of the transfer rule, HEW "has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements." *Michael Reese Physicians & Surgeons, S.C.* v. *Quern*, 606 F.2d 732, 735–736 (7th Cir. 1979). Based on the preceding, not only do we believe that the letter rulings should not be followed, but we also believe that HEW's general acceptance of California's Medi-Cal program supports our interpretation.

As further support for their argument under § 1396a (a)(10)(C), the appellants rely upon the subsequent legilsative history of the Medicaid program. In 1978, as part of the Medicare-Medicaid Administrative and Reimbursement Reform Act, the Senate Finance Committee proposed an amendment to the Medicaid statute which would have specifically required states to adopt transfer rules such as California's. S. Rep. No. 95–1111, 95th Cong., 2d Sess., 24–25 (1978). Apparently, relying upon what we have already concluded was an erroneous agency interpretation of § 1396a(a)(10)(C), the Senate Committee said that the states were not able to adopt transfer rules under present law. *Id.* We recognize that the pronouncements of legislative committees as to the meaning of previously enacted statutes are often afforded considerable deference. *Sioux Tribe of Indians* v. *United States*, 316 U.S. 317, 329–330, 62 S.Ct. 1095, 86 L.Ed. 1501 (1942). Nevertheless, courts are not bound by such pronouncements and it has been suggested that subsequently expressed Congressional views should not be relied upon at all. *Mathews* v. *Weber*, 423 U.S. 261, 272 n.7, 96 S.Ct. 549, 46 L.Ed.2d 483 (1976). Since the Senate Committee was apparently relying upon the erroneous administrative interpretation, and because we remain convinced that our interpretation of § 1396a(a)(10)(C) is correct, we choose

not to accord any deference to the latter legislative pronouncements.

We conclude that California's transfer rule does not conflict with 42 U.S.C. § 1396a(a)(10)(C).

B. *42 U.S.C. § 1396a(a)(17)(B)*

The appellants argue that the California transfer rule violates 42 U.S.C. § 1396a(a)(17)(B).[9] This section requires states to only consider the income and resources which are "available" to the applicant in determining eligibility. The California transfer rule assumes the availability of assets, which, according to the appellants, are no longer available to the applicant.

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[9] This statute provides in part as follows:

"A state plan for medical assistance must—

"include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) *provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and* (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or who have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) *in determining his eligibility for such aid, assistance, or benefits...*

***"

(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a) (17).

The appellants' argument may be correct under what we believe is an overly rigid and literal interpretation of the term "available" under § 1396a(a)(17)(B). We refuse to interpret this statute as equating available with present record title. This would be inconsistent with the approach which is taken under the Medicaid program.

Initially, "we do not lose sight of the [Medicaid] statute's strong emphasis upon flexibility in determining eligibility." *Norman*, *supra*, 610 F.2d at 1240. In another context the Supreme Court interpreted § 1396a(a)(17) as conferring broad discretion on the states to adopt reasonable standards. *Beal* v. *Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed. 464 (1977).[10] The California transfer rule presumes that an asset remains available to an applicant after the applicant has given it away, or sold it for less than adequate consideration. We find nothing in the plain language of this statute which would prohibit such a rule, nor is there anything in the legislative history which equates "available" as requiring present record title or ownership.

To the extent that the regulations address the definition of "available," they support our interpretation. Under the regulations, a state is allowed to examine an applicant's income and assets for a six-month prospective period in determining eligibility. 42 C.F.R. §§ 435.831(a), 435.845(b). Since a state is authorized to consider future assets, it must follow that it should also be allowed to consider those assets which have been recently disposed of under circumstances which indicate that the purpose was to qualify for public medical assistance.

We hold that California's transfer rule does not conflict with 42 U.S.C. § 1396a(17)(B).

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[10] The Supreme Court was considering the extent of medical assistance which the states were required to provide. *Beal*, *supra*, 432 U.S. at 444.

C. *42 C.F.R. § 435.401*

Appellants also claim that the California transfer rule is inconsistent with 42 C.F.R. § 435.401.[11] This regulation provides that a state Medicaid agency cannot use requirements for determining eligibility for the *medically needy* which are "more restrictive" than those used for the *categorically needy*. Since the California transfer rule is a more restrictive requirement, the appellants reason that it therefore violates § 435.401.

While we agree that the California transfer rule imposes a more restrictive requirement on the *medically needy*, we do not believe that § 435.401 has any bearing on the validity of financial eligibility requirements such as the transfer rule.

First of all, if we were to give § 435.401 the broad reading attributed to it by the appellants, we would be reading an inconsistency into the federal statutory and regulatory framework. The Medicaid program is designed to provide benefits to two differently situated groups. The *medically needy* are those individuals who have more available income and resources than the *categorically*

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[11] This regulation provides as follows:

"(a) A medicaid agency may not impose any eligibility requirement that is prohibited under title XIX of the Act.

"(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and that are consistent with the objectives of title XIXX.

"(c) *The agency must not use requirements for determining eligibility for optional coverage groups that are–*

"(1) For families and children, more restrictive than those used under the State's AFDC plan; and

"(2) *For aged, blind, and disabled individuals, more restrictive than those used under SSI,* except for individuals receiving an optional State supplement as specified in § 435.230 or individuals in categories specified by the agency under § 435.121."

(emphasis added to show that portion of the regulation which the appellants rely upon)

42 C.F.R. § 435.401.

needy. By definition, different financial requirements apply to the *medically needy* than to the *categorically needy*. Only when § 435.401 is read as not applying to financial requirements, such as the transfer rule, can it be viewed consistently with the other Medicaid statutes and regulations.

After all, § 435.401 is merely one of five sections under the general heading entitled: "*Subpart E—General Eligibility Requirements.*" There is absolutely no discussion of financial eligibility requirements in any of the other sections of this subpart. Instead, the focus of all of the sections is directed toward much more general concerns, such as eligibility requirements which are based on citizenship, alienage, or state residence. In addition, a thorough reading of the statutes and regulations shows that the sections of Subpart E parallel the subsections of 42 U.S.C. § 1396a(b). From this it is apparent that Subpart E (including § 435.401) was designed to carry out the statutory mandate of 42 U.S.C. § 1396a(b) which does not involve financial eligibility requirements. *See, e.g., Pacific Coast, supra*, slip op. at 2526.[12] And finally, there are three specific subparts which cover the financial eligibility requirements. Subpart G states the general financial eligibility requirements, Subpart H states the financial eligibility requirements for the *categorically needy*, and Subpart I states the financial eligibility requirements for the *medically needy*. These specific and detailed guidelines for financial eligibility requirements must control over the general rule of § 435.401.

We conclude that 42 C.F.R. § 435.401 does not apply to financial eligibility requirements and therefore there is no conflict between it and the California transfer rule.

D. *Due Process*

In their opening brief, the appellants claim that the transfer rule creates a rebuttable presumption in violation

[12] In *Pacific Coast, supra*, this court noted that "[e]xisting regulations must be construed in light of the statutory mandates under which they issue." Slip op. at 2526.

of the due process. In their reply brief, the appellants call it an "effectively" irrebuttable presumption. We disagree with either characterization and find that the transfer rule creates a rebuttable presumption which is permissible under the due process clause.

The California transfer rule obviously does not create an irrebuttable presumption. After all, the regulations expressly provide that the presumption may be overcome by evidence that the applicant had adequate resources for support and medical care at the time of the transfer of property. 22 Cal. Admin. Code § 50409(b)(2). Such a determination can be based on "such things as the applicant's . . . age, health, life expectancy, and ability to understand [the] extent of [his or her] resources." *Id.* This would mean that if a person was in good health at the time of the transfer, then the presumption might be rebutted because the person would have no reason to anticipate any large expenditure for medical care and support.

The appellants argue that it is an "effectively" irrebuttable presumption because the applicant is precluded from relying on his or her subjective intent. According to the appellants, this excludes the two most likely explanations for this type of transfer, which are: (1) the applicant was unaware of Medi-Cal benefits, and/or (2) a desire to avoid probate. While the state could have considered these subjective considerations, we cannot say that the failure to do so creates a due process violation. California's objective test for determining how the presumption can be overcome does not create an effectively irrebuttable presumption which might run afoul of the due process clause.

E. *Equal Protection*

The appellant's final argument is based on equal protection grounds. They claim that there is no rational basis for treating the *medically needy* any differently from the *categorically needy*. According to the appellants, the *medically needy* are in the identical situation as the *categorically needy*, that is, in need of medical care and without sufficient income or resources to pay for it. Since the "transfer of assets" rule only applies to the *medically*

needy, the appellants argue that it violates the equal protection clause because there is no reasonable basis for the disparate treatment between the two groups.

We fail to see how the application of the transfer of assets rule to the *medically needy* group gives rise to even a colorable constitutional claim under the equal protection clause.

Initially, we note that the two groups are not identically situated. By definition, the *categorically needy* have less income and resources than the *medically needy*. Furthermore, Congress has obviously viewed the two groups differently, or, at least, as not being identically situated. Why else would Congress have left the decision to provide benefits to the *medically needy* entirely up to the individual state? It must be remembered that the *categorically needy* receive benefits regardless of whether a state adopts a medicaid program under Title XIX. However, the *medically needy* only become entitled to benefits if a state first adopts a program, and, secondly, if the state elects to include the *medically needy* group in its benefit program.

In addition, California has a rational basis for its transfer rule. California is confronted with two competing interests, the protection of a limited public treasury, and the provision of benefits to those who are in need. The transfer rule was a reasonable response to these conflicting concerns. Under the rule, benefits are provided to those individuals who, in fact, have a financial need, and benefits are denied to the individuals who have artificially created a need by disposing of assets for less than fair consideration.

We hold that California's transfer rule is rationally related to the legitimate government objectives of protecting the public treasury and discouraging intentional impoverishment so as to qualify under a public assistance program. Any disparate treatment resulting from the application of the rule is sufficiently rational to be upheld against appellants' equal protection challenge. *See Dandridge, supra*, 397 U.S. at 471; *Richardson* v. *Belcher*, 404 U.S. 78, 83–84, 92 S.Ct. 254, 30 L.Ed.2d 231 (1972); *Sims* v. *Harris*, 607 F.2d 1253 (9th Cir. 1979).

III. Conclusion

In upholding the California's transfer rule, we recognize that the majority of the courts which have been faced with similar challenges have reached the opposite conclusion. *See, e.g., Caldwell* v. *Blum*, F.2d No. 79-7864 (2d Cir. April 10, 1980); *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir. 1979); *Udina* v. *Walsh*, 440 F.Supp. 1151 (E.D. Mo. 1977); *Buckner* v. *Maher*, 424 F.Supp. 366 (D. Conn. 1976), *aff'd* 434 U.S. 898, 98 S.Ct. 290, 54 L.Ed.2d 184; *Owens* v. *Roberts*, 377 F.Supp. 45 (M.D. Fla. 1974); *contra*, *Rinefierd* v. *Blum*, 412 N.Y.S. 2d 526 (App. Div. 1979); *Lerner* v. *Division of Family Services*, 235 N.W. 2d 478 (Wis. 1975). Nevertheless, for the reasons stated in this opinion, we are convinced that our analysis of the question is correct.

AFFIRMED.[13]

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[13] Appellants also ask this court, providing they prevail on this appeal, to grant the full measure of relief requested in their complaint and provide notice to all classmembers. Because we affirm the district court, it is unnecessary for us to address the propriety of this request.

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ROSSYE DAWSON, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, PLAINTIFF-APPELLANT,

vs.

BEVERLEE A. MYERS, ET AL., DEFENDANTS-APPELLEES.

Before: WRIGHT AND ANDERSON, Circuit Judges, and SOLOMON,* District Judge.

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for a rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The motion of the Secretary of Health and Human Services for permission to file an amicus curiae brief is DENIED.

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

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* The Honorable Gus J. Solomon, Senior United States District Judge, District of Oregon, sitting by designation.

In the Supreme Court of the United States

No. 80-5303

ANTONIA BELTRAN,
PETITIONER

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH, ET AL.

ON PETITION FOR WRIT OF CERTIORARI to the United States Court of Appeals for the Ninth Circuit.

On Consideration of the motion for leave to proceed herein *in forma pauperis* and of the petition for writ of certiorari, it is ordered by this Court that the motion to proceed *in forma pauperis* be, and the same is hereby, granted; and that the petition for writ of certiorari be, and the same is hereby, granted limited to Question 1 presented by the petition.

November 3, 1980

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Supreme Court, U. S.
FILED
SEP 26 1980
MICHAEL RODAK, JR., CLERK

80-5303

NO. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

ANTONIA BELTRAN
~~ROSSIE DAWSON~~, individually and on behalf of all others similarly situated,

Petitioner,

v.

BEVERLEE A. MYERS, individually and in her official capacity as Director of the California State Department of Health; and ELISABETH LYMAN, individually and in her official capacity as Deputy Director of the State Department of Health,

Respondents.

BRIEF IN OPPOSITION TO THE
PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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NO. 80 -

IN THE

SUPREME COURT OF THE UNITED STATES

October Term. 1980

ROSSYE DAWSON, individually and on behalf of all others similarly situated,

Petitioner,

v.

BEVERLEE A. MYERS, individually and in her official capacity as Director of the California State Department of Health; and ELISABETH LYMAN, individually and in her official capacity as Deputy Director of the State Department of Health,

Respondents.

BRIEF IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

QUESTIONS PRESENTED

1. Whether California's transfer of assets rule which denies benefits to any individual who has transferred assets so as to qualify for medical assistance (Medi-Cal) conflicts with the federal Medicaid statutes and regulations?

2. Whether California's transfer of assets rule which denies benefits to any individual who has transferred assets so as to qualify for medical assistance (Medi-Cal) violates the due process and equal protection clauses of the Fourteenth Amendment?

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LIST OF PARTIES

Respondents: Beverlee A. Myers, Director of the Department of Health Services erroneously identified as its predecessor, the Department of Health,

Elisabeth Lyman, Deputy Director of the Department of Health Services erroneously identified as its predecessor, the Department of Health.

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STATEMENT OF THE CASE

1. California has voluntarily chosen to participate in the Medicaid program. (42 U.S. C. § 1396 et seq.) A requirement of such participation is the adoption of a state plan for medical assistance which conforms to federal guidelines. After the Secretary of the Department of Health and Human Services (HHS) approves the individual state plan, the state is eligible to receive federal financial assistance for its program. California's state plan for medical assistance (the Medi-Cal program) was approved by HHS and California is presently receiving federal financial participation.

One federal requirement for a state which operates a Medicaid program is that it must provide coverage to a group of persons known as the "categorically needy" - those individuals who receive financial assistance under Title IV-A or Title XVI of the Social Security Act. (42 U.S.C. § 1396a(a)(10)(A).) States also have the option of covering a group known as the "medically needy" - those individuals who would qualify for Title IV-A or Title XVI financial assistance except that they have sufficient income and resources to cover their essentials apart from medical expenses. The chief distinction between the two groups is that the categorically needy have lower incomes and less resources than the medically needy.

2. California's transfer of assets rule (Cal. Welf. & Inst. Code § 14015; Petitioners' App.D, at 35) and the regulations implemented thereunder (22 Cal. Admin. Code §§ 50408, 50409; Petitioners' App. D, at 35) apply only to the medically needy group. The rule creates a rebuttable presumption that any transfer of assets for less than adequate consideration within two years prior to applying for assistance was made with the intent to qualify for medical assistance. The applicant has the opportunity to rebut the presumption by providing evidence "that adequate resources were available at the time of the transfer of property

for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources." (22 Cal. Admin. Code § 50409; Petitioners' App. D, at 35.) The failure to rebut the presumption will result in the ineligibility for Medi-Cal for a specified period of time.

3. Rossye Dawson, on behalf of herself and others similarly situated instituted this action on June 19, 1978 by filing a complaint for declaratory and injunctive relief in the district court for the Central District of California. The gravamen of the complaint was that California's transfer of assets rule contradicted applicable portions of the Social Security Act and thus violated the Supremacy Clause. The rule also allegedly violated the equal protection and due process clauses of the Fourteenth Amendment. Plaintiff Dawson has since died.

Two other individuals, Beltran and Manahan, intervened seeking the same relief. Both plaintiffs transferred all or part of their interest in their homes to relatives. Both plaintiffs were denied Medi-Cal benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. And none of the plaintiffs were able to overcome the presumption that they had transferred their assets with the intent to qualify for assistance.[1/]

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1. With respect to Beltran, the county computed her period of ineligibility to be 885 months. As a practical matter, Beltran would not be ineligible for 885 months because the ineligibility period would be substantially reduced by deducting the amount of medical expenses incurred in the convalescent center. (Title 22, Cal. Admin. Code §§ 50411 and 50605.)

The district court certified a class consisting of all those who had been denied Medi-Cal benefits because of California's transfer of assets rule. Plaintiff Manahan died while the case was before the Court of Appeals.

4. On May 10, 1979, the district court granted California's motion for summary judgment and denied plaintiff's cross motion for summary judgment. (Petitioners' App. B, at 22.) The court found that California's transfer of assets rule did not conflict with the Supremacy Clause nor constitute a denial of equal protection or due process. (Petitioners' App. B, at 24.)

5. On May 11, 1979, plaintiffs appealed to the Court of Appeals for the Ninth Circuit. Plaintiffs also sought injunctive relief for the class and certain individuals while the appeal was pending. Plaintiffs argued that unless injunctive relief were granted there would be mass eviction of class members from nursing homes. Whereas the Court granted injunctive relief for individual members, relief was denied for the class. In a decision dated May 14, 1980, a three-judge panel of the Court of Appeals for the Ninth Circuit affirmed the judgment of the district court for the Central District. The decision upheld California's transfer of assets rule and rejected all of plaintiffs' arguments. (Petitioners' App. A at 1.) In upholding California's transfer rule, the court was not unmindful of the fact that the majority of the courts which had been faced with similar challenges reached the opposite conclusion. (Petitioners' App. A, at 16.) The panel, in affirming the district court below, upheld a state rule designed solely to protect the fiscal integrity of California's Medi-Cal program and to reserve the state's limited financial resources for those truly in need of medical assistance.

6. Plaintiffs filed petitions for rehearing and rehearing en banc. On July 21, 1980, the Secretary of HHS made a motion for permission to file an amicus curiae brief. On July 30, 1980, a three-judge panel voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc. The full court was advised of the suggestion for en banc rehearing and no judge of the court requested a vote on the suggestion. In addition, the motion of the Secretary of HHS for permission to file an amicus curiae brief was denied. (Petitioners' App. C, at 33.) The plaintiffs then filed the within petition for writ of certiorari.

ARGUMENT

Petitioners attempt to characterize the decision of the Court of Appeals for the Ninth Circuit as in direct contradiction to every other court which has considered the validity of a transfer of assets rule. Respondents would simply submit the two lower courts--the district court below and the district court in Maryland (Fabula v. Solomon (1978) 463 F.Supp. 830)--have agreed with the position of respondents and the decision of the panel. In the state courts, although the Appellate Division of the New York Supreme Court has struck down the New York transfer of assets rule (Scarpuzza v. Blum--A.D.2d--- synopsis at CCH Medicare & Medicaid Guide, ¶ 30,404), the Supreme Court of Wisconsin has upheld Wisconsin's transfer of assets rule. (Lerner v. Division of Family Services (1975) 70 Wis.2d 670, 235 N.W.2d 478.) The panel was certainly not unmindful of the fact that other courts have reached the opposite conclusion. The panel is not, however, as much of a maverick as the petitioners would like to believe.

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Respondents, in opposing the issuance of the writ, are not unaware of the fact that other federal courts of appeals have rendered decisions in conflict with the panel's decision. However, inasmuch as petitioners have also addressed the merits in their petition, the respondents feel compelled to briefly discuss some of the substantive issues raised by petitioners in order to afford the court a clearer picture of the matter under review.

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CALIFORNIA'S TRANSFER OF ASSETS RULE DOES NOT VIOLATE THE SUPREMACY CLAUSE AS IT DOES NOT CONFLICT WITH ANY FEDERAL STATUTE OR REGULATION

Persons who comprise the class which includes the named plaintiffs have all been found to have transferred their assets for less than adequate consideration "with the intent to qualify for assistance" (Cal. Welf. & Inst. Code § 14015). All of them were found to have had sufficient assets to support their present medical needs. The purpose in implementing the transfer of assets rule is not so much to penalize these individuals. It is rather to preserve state funds for those persons who are truly in need of government-funded medical care. The United States Supreme Court recognized this when it said that restrictions on welfare eligibility attempt "to promote self-reliance and civic responsibility, to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most in need, and to cope with the fiscal hardships enveloping many state and local governments. . . ." (New York Dept. of Social Services v. Dublino (1973) 413 U.S. 405, 413.) The Medi-Cal system could not long survive the drain on its funds if individuals in the state who transferred assets for inadequate consideration with the intent to qualify for assistance were eligible for medical assistance. And, certainly, the "self-reliance" and "civic responsibility" about which the Supreme Court spoke would not be promoted by such attempts to qualify for assistance at the expense of the public treasury.

These policy considerations would carry little weight in the face of explicit federal statutes or regulations prohibiting the state's imposition of a transfer of assets rule.

However, no such statutes or regulations exist. Nowhere in either Title XIX of the Social Security Act or the regulations promulgated thereunder is there any mention of a prohibition against transfer of assets rules. In fact, the only logical reading of those statutes and regulations is that a state may impose different income and resource eligibility criteria on the optional medically needy group than are imposed on the categorically needy.

Petitioners argue that California's transfer of assets rule violates the Supremacy Clause in that it conflicts with portions of the Social Security Act and applicable regulations. Specifically, petitioners allege that the rule conflicts with 42 United States Code section 1396a(a)(10)(C) and 42 United States Code section 1396a(a)(17)(B) because it imposes an additional requirement on the medically needy which is not imposed on the categorically needy. The Court of Appeals found no conflict with any of these sections. (Petitioners' App. A, at 10, 11, 12.) Respondents submit that the Court reached the correct decision based upon the language of those sections and applicable case law.

Medicaid has been described as an experiment in cooperative federalism with boundless options. (Michael Reese Physicians and Surgeons, S.C. v. Quern (7th Cir. 1979) 606 F.2d 732, 735.) The United States Supreme Court has recognized that states face the "critical problem of mounting welfare costs and the increasing financial dependency of many of its citizens." The severity of these problems requires that states be given "considerable latitude in attempting their resolution." (New York Dept. of Social Services v. Dublino, supra.)

The starting point in any analysis involving the Supremacy Clause is the basic principle that the courts will not assume that a federal statute was intended to supersede the

exercise of a valid state power unless clearly and unambiguously stated. In Dublino, supra, the Supreme Court held:

> "This Court has repeatedly refused to void statutory programs, absent congressional intent to pre-empt them.
>
> > 'If Congress is authorized to act in a field, it should manifest its intention clearly. It will not be presumed that a federal statute was intended to supersede the exercise of the power of the state unless there is a clear manifestation of intention to do so. The exercise of federal supremacy is not lightly to be presumed.' Schwartz v. Texas, 344 U.S. 199, 202-203 (1952)." (405 U.S. 413.)

The principle becomes even more applicable under the Medicaid program as Congress has expressly required state Medicaid programs to adopt certain procedures to curb abuses and has not prevented state welfare departments from instituting other reforms that would fall within their discretion in administering these programs. (Michael Reese Physicians and Surgeons, S.C. v. Quern, supra.)

Neither the statutes nor the regulation upon which petitioners rely specifically prohibit the state's imposition of a transfer of assets rule. Petitioners can point to no provision in the Social Security Act which mandates that states may only use eligibility requirements explicitly authorized by federal statute. Petitioners can likewise find no requirement that the eligibility rules for the optional medically needy group must be identical to those applied to the categorically needy.

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California's transfer rule does not conflict with 42 United States Code section 1396a(a)(10)(C). (Petitioners' App. D, at 34.) The plain meaning of this section is that a state must make medical assistance available to the medically needy to the same extent as the categorically needy, except for income and resource requirements. As the panel correctly held, the transfer of assets rule is clearly an income and resource eligibility criterion. Petitioners misconstrue the law when they argue that federal law requires that no more restrictive eligibility conditions be employed against the medically needy than against the categorically needy. Section 1396a(a)(10)(C) excludes income and resource criteria from these requirements. If the exact same eligibility conditions were employed for the two groups, there would be no difference between them. The transfer of assets rule is a financial eligibility condition which directly affects an individual's income and resource levels. Section 1396a(a)(10)(C) specifically permits such differentiation between the two groups of covered individuals.

The second part of section 1396a(a)(10)(C) requires that a state plan must make medical assistance available to individuals "who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services. . . ." (Petitioners' App. D, at 34.) Congress has given some guidance on which beneficiaries shall have their eligibility determined by "comparable" standards. The legislative history of Title XIX is clear that by "comparable standards" of income and resources, Congress intended to require comparability as among the different groups of medically needy, rather than comparability between the categorically needy and the medically needy. (S.Rpt. 404, 89th Cong., 1st Sess., 1965 U.S. Code Cong. & Admin. News at p. 2017.)

"Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children, who except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal." (Emphases added.)

Congress, therefore, required that, among the medically needy, the aged, the blind and the disabled must have their eligibility determined by comparable income and resource limitations. It did not require comparability as between the categorically needy and the medically needy.

Even if the second part of section 1396a(a)(10)(C) is read as requiring comparability between the categorically needy and the medically needy, the Ninth Circuit found:

"The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the medically needy group (including the transfer rule) are not comparable to those which are used under the SSI program." (Petitioners App. A, at 8.)

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Petitioners base their argument on letters written by Regional Administrators of HHS stating that state transfer rules are inconsistent with section 1396a(a)(10)(C) because they impose more restrictive requirements on the medically needy than on the categorically needy. As the panel noted, however, an agency's interpretation of its regulations is not entitled to complete deference. As the Court of Appeals for the Ninth Circuit held in a recent case dealing with the HHS's interpretation of certain Medicare regulations:

> "The deference which a reviewing court is to afford to an agency's interpretation of its regulations is not total, however. Congress has vested in the court a reviewing function over the action of the agency, including its interpretative decisions. 42 U.S.C. § 1395oo(f), 5 U.S.C. §§ 701-706. We would be abdicating our judicial responsibility if we were to pass on the propriety of the Secretary's interpretation without subjecting it to some degree of scrutiny. As where courts review an agency's construction of a statute which the agency administers, 'the deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia . . . .' American Ship Building Co. v. NLRB, 380 U.S. 300, 318 (1965); Volkswagenwerk Aktiengesellschaft v. Federal Maritime Commission, 390 U.S. 261 (1968). Even though the Medicare reimbursement area is complex, and to a great degree left to the Secretary to structure, his interpretations are nonetheless subject to our examination." [Footnotes omitted.] (Pacific Coast Medical Enterprises v. Harris (9th Cir. March 28, 1980) ___F.2d___, slip op. 2516, 2525-2526.)

In another Ninth Circuit case, the court held that the congressional policy underlying a statute as well as other compelling policy considerations are of equal if not greater importance.

> "However, the courts do not merely 'stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute.' NLRB v. Brown, 380 U.S. 278, 291, 85 S.Ct. 980, 988, 13 L.Ed.2d 839 (1965), quoted in Volkswagenwerk v. FMC, 390 U.S. 261, 272, 88 S.Ct. 929, 935, 19 L.Ed.2d 1090 (1968). Nor will the courts 'defer to an administrative construction where there are compelling indications that it is wrong.' Marathon Oil Co. v. Kleppe, 556 F.2d 982, 986 (10th Cir. 1977.)" (Baker v. United States (9th Cir. 1980) 613 F.2d 224, 227.)

In the case at bar, Congress has given the states wide latitude in the administration of their Medicaid programs. Further in 1972, Congress repealed section 1396b(e) of Title 42, a statute which required a state to make efforts in the direction of broadening the scope of care and services and in the direction of liberalizing the eligibility requirements for medical assistance. (Pub.L. 92-603, Title II, § 230, 86 Stat. 1410.) By repealing this statute, Congress recognized its awareness of the fiscal crises confronting states in the administration of their Medicaid programs. The effect of upholding the interpretation taken by HHS's regional administrators would be to make Medi-Cal available to any aged, blind or disabled person, or any AFDC family regardless of whether that individual or family had insufficient income and resources for medical needs. Such a result flies directly in

the face of the Congressional intent of alleviating the fiscal burdens of state Medicaid programs.

Furthermore, HHS's opinion of the transfer of assets rule is far from consistent. HHS has approved California's state plan in spite of the fact that the transfer rule (Cal. Welf. & Inst. Code § 14015) has been in effect since 1965. The Seventh Circuit found this a very persuasive factor in determining whether statutory and regulatory requirements had been violated. In Michael Reese Physicians and Surgeons, S.C. v. Quern, supra, (7th Cir. 1979) 606 F.2d 732, the court was faced with a challenge to an Illinois regulation which allegedly violate a federal Medicaid statute. In upholding the regulation, the court said:

> "In passing the Medicare and Medicaid Antifraud and Abuse Amendments, Congress required state programs to adopt certain procedures to curb abuses. Congress did not prevent state welfare departments from instituting other reforms which would fall within their discretion in administering the Medicaid programs. Medicaid is an experiment in cooperative federalism, [citations omitted], which literally abounds with options, [citations omitted]. Medicaid is designed to be flexible enough to meet the varying needs of each state which elects to participate in the program. By approving the Illinois Medicaid plan, and by declining thus far to take any action against the modification in the plan, the Department of Health, Education and Welfare has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements." (Emphasis added.) (606 F.2d at pp. 735-736.)

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The Ninth Circuit's decision to accord little weight to the interpretations of HHS is consistent with the district court decision of Robinson v. Pratt, No. 79-1278-S (D.Mass., June 24, 1980). This court determined that no private right of action exists under section 1396a(a)(10)(C), and that the requirements of this section are merely conditions of federal participation in the Medicaid program. The court stated:

> "It is equally clear that compliance with 42 U.S.C. § 1396a(a)(10)(C) is not mandated as a rule of law to be enforced by the courts, but is mandated only as a condition of federal participation in a Medicaid program.
>
> "The enforcement of this statute has not been committed to the courts to be executed through private right of action. Such judicial enforcement would interfere with the discretion expressly vested in the Secretary. I perceive her invitation to the court to intervene as a total distortion of the statutory scheme and as an attempt to avoid a thorny political decision, i.e., an abdication of responsibility." (Robinson v. Pratt, supra, at p. 9.)

II

THE CALIFORNIA TRANSFER OF ASSETS RULE DOES NOT VIOLATE THE FEDERAL REQUIREMENT THAT ONLY AVAILABLE INCOME AND RESOURCES BE CONSIDERED IN DETERMINING ELIGIBILITY

Petitioners contend that California's transfer of assets rule is violative of 42 United States Code section 1396a(a)(17)(B) in that only actually available income and resources may be considered in eligibility determinations under the Medicaid program. (Petitioners' App. D, at 34.) This argument is not supported, however, by case authority interpreting this very provision.

A —

In Lerner v. Division of Family Services (Wis. 1975) 235 N.W.2d 478, the Supreme Court of Wisconsin held that the Wisconsin transfer of assets rule did not violate Title 42 of the United States Code section 1396a(a)(17(B). The Wisconsin statute was very similar to California's. The court noted that Wisconsin's transfer rule -

> ". . . merely requires the petitioner to demonstrate that the lack of presently available resources is not the result of a divestment of property for the purpose of qualifying for benefits. Thus, the statutory provision is not in conflict with the federal statute and regulations, but is merely a procedure for determining what assets are, in fact, available to meet present needs or, but for divestment, would have been available. Petitioner is not precluded from making a showing that the specific divestment was not made in contemplation of benefits or without receiving full and adequate consideration. Any interpretation which finds conflict between the federal statute and the state provision would seem to allow for extensive abuse of the medical assistance program, since a failure to require the showing mandated by sec. 49.47(4)(d), Stats., could result in any and every person who meets the income eligibility requirements automatically becoming eligible for benefits by the simple expedient of giving away or signing over control of all measurable assets. Such a result could not have been contemplated by the legislature when it enacted Title XIX, nor by HEW when it promulgated regulations thereunder." (Lerner, supra, at pp. 483-484.)

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The cases cited by petitioners in support of their assertion that California's regulation violates Title 42 United States Code section 1396a(a)(17)(B) are inapposite. In Buckner v. Maher (D.Conn. 1976) 424 F.Supp. 366, aff'd. (1977) 98 S.Ct. 290, Udina v. Walsh (E.D.Mo. 1977) 440 F.Supp. 1151, the courts were dealing with statutes which disqualified applicants solely because of a transfer of assets. The statutes did not require that a finding be made that the applicant transferred such property with the intent to qualify for assistance. Unlike these statutes, California requires such a finding to be made. Thus, it does not violate due process.

Therefore, California's rule does not violate the federal requirement that only available resources shall be considered. Without a transfer rule any person could qualify for medical assistance by merely divesting themselves of sufficient assets. This would quickly bankrupt a state's medical assistance program and would result in the denial of all benefits to those truly in need. This could not have been the intent of the federal government when it enacted the Medicaid program.

III

CALIFORNIA'S TRANSFER OF ASSETS RULE DOES NOT VIOLATE THE DUE PROCESS OR EQUAL PROTECTION CLAUSES OF THE FOURTEENTH AMENDMENT

Petitioners argue that California's transfer of assets rule creates an irrebuttable presumption in violation of the due process clause. By its terms, the rule is rebuttable. The applicant has the opportunity to rebut the presumption by providing evidence "that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age,

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health, life expectancy and ability to understand extent of resources." (22 Cal. Admin. Code § 50409.) (Petitioners' App. D, at 35.)

Finally, petitioners argue that because the transfer rule only applies to medically needy, it violates the equal protection clause. This rule does not violate equal protection because it is rational for California to scrutinize transfer of assets by the medically needy to assure that financial eligibility is not manufactured and that medical assistance benefits are dispersed only to those truly in need. California's transfer rule, as the panel noted, is "rationally related to the legitimate government objectives of protecting the public treasury and discouraging intentional impoverishment so as to qualify under a public assistance program." (Petitioners' App. A, at 15.)

CONCLUSION

Based on the foregoing, a writ of certiorari should not issue to review the decision of the Ninth Circuit.

DATED: September 23, 1980.

Respectfully submitted,

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9-23-80

NO. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

ROSSYE DAWSON, et al.,

Petitioner,

v.

BEVERLEE A. MYERS, et al.,

Respondents.

CERTIFICATE OF SERVICE
(Rule 28.5)

I, Anne S. Pressman, a member of the bar of the Supreme Court, do hereby certify that, pursuant to Rule 28.5 of the Rules of this Court, I have served on this 24th day of September, 1980, three copies of the Brief in Opposition to the Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit, with postage thereon fully prepaid, in the United States mail at Los Angeles, California addressed to:

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I further certify that all parties required to be served have been served.

ANNE S. PRESSMAN
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JAN 23 PAGE 10

Office-Supreme Court, U.S.
FILED
JAN 21 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-5303

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

ANTONIA BELTRAN, individually and on behalf of all others similarly situated,

Petitioner,

v.

BEVERLEE A. MYERS, individually and in her official capacity as Director of the California State Department of Health; and ELISABETH LYMAN, individually and in her official capacity as Deputy Director of the State Department of Health,

Respondents.

RESPONDENTS' OPPOSITION TO MOTION OF PETITIONER FOR SUMMARY REVERSAL AND REMAND IN PART, AND FOR VACATION AND REMAND IN PART DUE TO INTERVENING LEGISLATION

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RESPONDENTS' OPPOSITION TO MOTION OF PETITION FOR SUMMARY REVERSAL AND REMAND IN PART, AND FOR VACATION AND REMAND IN PART DUE TO INTERVENING LEGISLATION

The Boren/Long Amendment No. 1936 (hereinafter referred to as "Amendment") passed both the Senate and House of Representatives on December 13, 1980, as part of HR 8406 (see 1979-1980 CCH Congressional Index, p. 34,547 (December 19, 1980)) and was signed into law by the President on December 28, 1980. The slip law will be designated Public Law 96-611, § 5.

Petitioner contends that the nature of this legislation and its purpose, as explained in its legislative history, resolves the issue of this case for certain class members, and requests that this Court reverse summarily pursuant to Rule 23.1, Rules of the Supreme Court. In addition, petitioner contends that the case should be remanded for other members of the class who will apply after July 1, 1981. Petitioner's position, however, is untenable.

Respondents have argued at all levels of this litigation that California's transfer of assets rule, under the law prior to the Amendment, does not violate the Supremacy Clause as it does not conflict with any federal statute or regulation. The recent enactment of the Boren/Long Amendment and accompanying legislative intent is in fact supportive of respondents' position. The Boren/Long Amendment is an explicit expression of legislative intent that states should be permitted to apply transfer of assets rules in the Medicaid program, in addition to the Title XVI SSI/SSP cash assistance program. This legislation, especially in light of recent court decisions, was found necessary to correct the practice whereby persons with substantial assets intentionally divest themselves of such assets so that the costs of long-term institutional care will be borne

by the state through its medical assistance program. The enactment of the Boren/Long Amendment cannot be interpreted as a statement of Congress' opinion that, prior thereto, states could not apply transfer of assets rules to the Title XIX Medicaid program. Courts have acknowledged that the use of subsequent legislative pronouncements form a hazardous basis for inferring the intent of an earlier Congress. Furthermore, certain reports of the Senate Finance Committee explicitly state that legislation allowing states to apply transfer rules should not be construed as agreement with those decisions which have struck down such rules.

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THE ENACTMENT OF THE BOREN/LONG AMENDMENT CANNOT BE INTERPRETED AS A STATEMENT OF CONGRESS' OPINION THAT, UNDER THE LAW PRIOR TO THE AMENDMENT, STATES COULD NOT APPLY TRANSFER OF ASSETS RULES IN THE MEDICAID PROGRAM

A. The Amendment Is An Explicit Expression Of Legislative Intent That States Should Be Permitted to Apply Transfer of Assets Rules In The Medicaid Program.

Respondents submit that California's transfer of assets rule, under the law prior to the Amendment, does not violate the Supremacy Clause as it does not conflict with any federal statute or regulation. Although other courts have reached a contrary conclusion,[1/] respondents have argued in their Brief on file with this Court that the Court below, as well as several concurring courts, have reached the correct decision based on the language of those sections and applicable case law. (Dawson v. Beach No. 78-2350 (C.D. Cal. 1979), aff'd. sub nom. Dawson v. Myers, 622 F.2d 1304 (9th Cir. 1980); J.A. 52; J.A. 56; Fabula v. Solomon 463 F.Supp. 830 (D. Md. 1978), rev'd. sub nom. Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979); Lerner v. Division of Family Services 235 N.W.2d 478 (Wis. 1975); Rinefierd v. Blum 412 N.Y.S.2d 526 (4th Dept. 1979).)

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1. Fabula v. Buck (4th Cir. 1979) 598 F.2d 869, Scarpuzza v. Blum (2d Dept. 1980) 426 N.Y.S.2d 505. Both the lower court in Caldwell v. Blum (CCH Medicare and Medicaid Guide, para. 30,093 (N.D.N.Y. 1979)) and the Second Circuit, Caldwell v. Blum (2d Cir. 1980) 621 F.2d 491, pet. for cert. pending No. 79-2034 (filed June 24, 1980), as well as Robinson v. Pratt (CCH Medicare and Medicaid Guide, para. 30,605 (D. Mass. 1980)) also found the transfer of assets rule violative of the Supremacy Clause in those states which did not elect the option available in 42 U.S.C. sec. 1396a(f). These latter three decisions were not final rulings on the merits, but were in the context of motions for a preliminary injunction.

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The enactment of the Boren/Long Amendment is supportive of respondent's position. The Amendment explicitly permits states to do that which states had the authority to do under the prior law, namely, to apply transfer of assets rules in the Title XIX Medicaid Program. The transfer rule under the Amendment is very similar to California's transfer of assets rule.[2/] (Welf. & Inst. Code, § 14015; 22 Cal. Admin. Code, §§ 50408, 50409.) It allows states to take into consideration the resources of an individual within the preceding two years if the individual gave away or sold assets for less than valuable consideration for the purpose of establishing eligibility for Medicaid. States may presume that the transfer was made for the purpose of becoming eligible for benefits, unless the applicant rebuts the presumption by furnishing convincing contrary evidence. The bill also establishes periods of time during which the states may deny the applicant's eligibility.

This legislation was found necessary to correct the frequently utilized practice whereby persons with substantial assets intentionally divest themselves of such assets so that the costs of long-term institutional are will be borne by the state through its medical assistance program. In arguing for the passage of his cosponsored amendment, Senator Russell Long charaterized a transfer of assets for the purpose of establishing eligibility for public assistance as:

> ". . . an abusive practice in which certain individuals transfer substantial assets to their families or to others in order to bring themselves down

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2. The Boren/Long Amendment No. 1936 to HR 8406, as it appears in the Congressional Record at 126 Cong.Rec. S16505 (daily ed. December 13, 1980) is set forth in the Brief of the Respondents at p. 40, fn. 22.

eligibility level which will qualify them for payments under the supplemental security income (SSI) program and for fully paid medical care under the medicaid program." (126 Cong.Rec. S16505 (daily ed. December 13, 1980).)

Senator Long recognized this "abusive practice" as a "substantial fiscal concern for many states." (Ibid.)

Further support for congressional recognition of the need to allow states to impose restrictions on the transfer of assets for the purpose of establishing eligibility for public assistance can be found in the legislative history of that reconciliation bill referred to by Senator Long (Senate Bill 2885). In the General Discussion of (the Senate) Finance Committee Amdendments to Senate Bill 2885 (126 Cong.Rec. S8248 (daily ed. June 26, 1980)), the following comments on the practice of transferring assets to establish SSI eligibility were made:

"The committee believes that it is inappropriate for the public assistance programs to be burdened with the assumption of the support and medical care of individuals who have ample personal resources. . . . The Committee recognizes that there may be cases in which such a transaction takes place in good faith and unforeseen circumstances subsequently require an individual to apply for assistance. The committee believes that such a situation would be quite rare; . . . ." (Emphasis added.) (126 Cong.Rec. S8250 (daily ed. June 26, 1980).)

Thus, with the enactment of the Boren/Long Amendment, Congress has explicitly recognized that states should be permitted to apply transfer of assets rules in the Medicaid program, in addition to the Title XVI, SSI/SSP cash assistance program.

B. Courts Have Recognized That The Use of Subsequent Legislative Pronouncements Form A Hazardous Basis For Inferring The Intent Of An Earlier Congress

Petitioner contends that the legislative history of the Boren/Long Amendment also supports her argument that, under existing law, California and other states are not permitted to apply transfer of assets rules. Petitioner made a similar argument before the Court below based on certain Senate Finance Committee reports. In 1978, as part of the Medicare-Medicaid Administrative and Reimbursement Reform Act, the Senate Finance Committee proposed an amendment to the Medicaid statute requiring states to adopt transfer rules similar to California's. (S. Rep. No. 95-1111, 95th Cong., 2d Sess., 24-25 (1978).) The Senate Committee stated at that time that states were unable to adopt transfer rules under the present law. (Dawson v. Myers (9th Cir. 1980) 622 F.2d 1304, 1308-1309; J.A. 66-67.) The Ninth Circuit, concluding that the Senate Committee was apparently relying on the federal agency's erroneous interpretation of section 1396a(a)(10)(C) of Title 42 of the United States Code, flatly rejected petitioner's argument. (Ibid.)

Petitioner, relying on recent statements of Senator Long, suggests that this Court should also defer to subsequent legislative history. (126 Cong.Rec. S16505 (daily ed., December 13, 1980).) The particular passage which petitioner quotes on page 2 of her motion does not demonstrate clear legislative intent that Congress intended that states could not, under existing law, impose a transfer of assets restriction. This use of subsequent legislative history to interpret a statute is of dubious value. The Court below correctly recognized that pronouncements by a subsequent Congress are not entitled to the same weight as those of the Congress which enacted a measure.

(Banco Nacional de Cuba v. Farr (2d Cir. 1967) 383 F.2d 166, 175, cert.den. (1968) 390 U.S. 956.) In United States v. Price (1960) 361 U.S. 304, 313, this Court stated that: ". . . views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." Furthermore, courts are not bound by such pronouncements and it has been contended that subsequently expressed congressional views should not be relied upon at all. (Dawson v. Myers, 622 F.2d at 1312; J.A. 66, citing Mathews v. Weber (1976) 423 U.S. 261, 272 fn. 7.) Inasmuch as the transfer rule does not conflict with section 1396a(10)(C) of Title 42 of the United States Code (Dawson v. Myers, 622 F.2d at 1312; J.A. 66-67), this Court should not accord deference to the subsequent legislative history of the Medicaid program.

C. Certain Reports Of The Senate Finance Committee Explicitly State That Legislation Allowing States To Apply Transfer Rules Should Not Be Construed As Agreement With Those Decisions Which Have Struck Down Such Rules

Not every amendment of a statute demonstrates legislative intent to make a major change in the substance or effect of a pre-existing law. (Oklahoma Tax Commission, et. al. v. Stanoline Pipeline Co. (10th Cir. 1940) 113 F.2d 853, 856.) Consideration of the surrounding circumstances may indicate that the amendment was merely the result of a legislative intent to clarify the true meaning of the pre-existing statute. In addition, an amendment may reflect the Legislature's desire to meet a new and unanticipated condition brought about by judicial interpretation of the pre-existing law. (Ibid.)

Certain reports of the Senate Finance Committee explicitly state that legislation allowing states to apply transfer of assets rules should not be construed as agreement with court decision which have struck down such rules. In 1980,

the Senate Finance Committee, as part of the budget reconciliation bill, supported an amendment (Senate Bill 2885, § 511) restricting transfer of assets in the Title XVI SSI/SSP cash assistance program and the Title XIX Medicaid program. (126 Cong.Rec. S8250 (daily ed. June 26, 1980).) Although this legislation passed the Senate, and was concurred in by the House, agreement could not be reached in the context of the reconciliation conference. (Ibid.) Senator Long, in commenting on the Boren/Long Amendment, referred to this section of the budget reconciliation bill. (126 Cong.Rec. S16505 (daily ed. December 13, 1980).) The Senate Finance Committee, in its explanation of the S2885 reconciliation provisions, specifically pointed out that its attempt to limit the disposal of assets for the purpose of establishing SSI eligibility should not be interpreted as agreement with the reasoning of the cases which had struck down transfer of assets rules.

> "The Committee has been told that transfers of this type frequently occur, particularly in cases where an aged individual may face substantial medical expenses. For example, in connection with protracted nursing home care, by transferring assets to a relative, the individual qualifies not only for SSI but also for medicaid. Moreover, under certain court decisions, the absence of an SSI provision in this area has been found to lead to similar problems in connection with the medically needy segment of the medicaid program. (The committee does not intend that its recognition of the existence of these court decisions should be construed as agreement that they are correct.)"
>
> ". . . . . ."

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"The committee is aware as indicated above, that certain courts have held that the absence of a provision of this type in the SSI statute precludes States from applying such a rule in 'medically needy' cases. The adoption of this provision will remedy the problems this has created for the States." (Emphasis added.) (126 Cong.Rec. S8250 (daily ed. June 26, 1980).)

Respondents submit that the foregoing statements demonstrate that the Senate Finance Committee was apparently aware in June 1980 of the decisions in New York (Caldwell v. Blum (2d Cir. 1980) 621 F.2d 491, pet. for cert. pending. (No. 79-2034); Scarpuzza v. Blum (2d Dept. 1980) 426 N.Y.S.2d 505) and in Maryland (Fabula v. Buck (4th Cir. 1979) 598 F.2d 869), invalidating transfer of assets rules. The Senate Finance Committee was concerned about remedying the problems created by these court decisions which found that state transfer of assets rules conflicted with the section 1396a(a)(10)(C) of Title 42 of the United States Code and thus violated the Supremacy Clause.

Therefore, the enactment of the Boren/Long Amendment and accompanying legislative intent should not be interpreted as a statement of congressional opinion that states could not, under the law prior to that Amendment, apply transfer of assets rules in their Title XIX Medicaid programs.

CONCLUSION

Based on the foregoing, petitioner's motion for summary reversal and remand in part should be denied. Petitioner also moves for vacation of the decision of the Court of Appeals and for remand for those class members who will apply on or after July 1, 1981. This relief is requested so that the district

court may determine whether California's transfer of assets rule will comply with federal law that will allegedly be implemented on July 1, 1981.[3/] Respondents would simply submit that this relief is beyond the scope of these proceedings. Whether California's transfer of assets rule complies with federal law and regulations, yet to be written or implemented, is not a question that should be decided in the context of this litigation. This issue is not ripe for judicial review. Therefore, respondents respectfully submit that petitioner's motion should be denied in toto.

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3. Petitioner contends that because there is no specific effective date section in section 5 of Pub. L. 96-611 which adds subsection (j) to the Medicaid statute, that this provision is subject to the law's general effective date of July 1, 1981. (Pub. L. 96-611, § 2.)

CERTIFICATE OF SERVICE

I, Richard J. Magasin, a member of the Bar of the Supreme Court, do hereby certify that I have served on the 19th day of January, 1981, one copy of RESPONDENTS' OPPOSITION TO MOTION OF PETITIONER FOR SUMMARY REVERSAL AND REMAND IN PART, AND FOR VACATION AND REMAND IN PART DUE TO INTERVENING LEGISLATION, with postage thereon fully prepared, in the United States mail at Los Angeles, California, addressed to:

GILL DEFORD
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I further certify that all parties required to be served have been served.

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RICHARD J. MAGASIN

Attorney for Respondents

No. 80-5303

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Petitioner,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH; AND ELISABETH LYMAN, INDIVIDUALLY AND AS DEPUTY DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether the application by California of a "transfer of assets" rule to its medically needy aged, blind, and disabled applicants for, and recipients of, Medicaid, resulting in the denial of assistance to individuals otherwise eligible, violates the applicable portions of the Social Security Act and thus the Supremacy Clause.

LIST OF PARTIES

Petitioner: Antonia Beltran
Respondents: Beverlee A. Myers and Elisabeth Lyman

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-5303

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Petitioner,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH; AND ELISABETH LYMAN, INDIVIDUALLY AND AS DEPUTY DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the Court of Appeals (J.A. 56) is reported at 622 F.2d 1304. The district court's unreported Findings of Fact and Conclusions of Law of May 10, 1979 appear in the Joint Appendix, at 47.

JURISDICTION

The Court of Appeals filed its Opinion on May 14, 1980. A timely petition for rehearing and rehearing *en banc* was denied on July 30, 1980, with the petition for certiorari filed on August 27, 1980. The Court granted the petition, limited to the Supremacy Clause argument, on November 3, 1980 (J.A. 75). Jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant federal provisions are 42 U.S.C. §§1396a(a)(10) and (17); 42 C.F.R. §435.401(c)(2); and the Social Security Administration Claims Manual, §12507(a). The relevant state provisions are California Welf. & Inst. C. §14015, and 22 Cal.Admin.C. §§50409, 50411(a). The pertinent texts of these provisions are set out verbatim in Appendix D to the petition for certiorari.

STATEMENT OF THE CASE

1. California participates in the Medical Assistance ("Medicaid") program, which was added by Title XIX of the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. §1396 *et seq.* The court below summarized the basic obligations inherent in this participation:

> "This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although

> states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. §1396a(b) . . . . After a state's plan is approved by the Secretary of [Health and Human Services], the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. §1396." *Dawson v. Myers,* 622 F.2d 1304, 1307 (9th Cir. 1980) (J.A. 57). See also, *e.g., Harris v. McRae,* ____ U.S. ____, 100 S.Ct. 2671, 2680 (1980).

Under the formula, California has received, and will continue to receive, fifty per cent of its costs as reimbursement from the federal government. 42 U.S.C. §1396b; 44 Fed.Reg. 10553 (1979); HHS Action Transmittal No. 80-75 (Oct., 1980).

Implicit in participation in the federal Medicaid program is that a state must comply with controlling federal law and regulations. *Harris v. McRae, supra,* 100 S.Ct., at 2680; *Fabula v. Buck,* 598 F.2d 869, 870-871 (4th Cir. 1979); see also, *e.g., Townsend v. Swank,* 404 U.S. 282, 286 (1971). In theory, the Secretary of the Department of Health and Human Services ("HHS")[1] can deprive the state of its matching funds, if, after a compliance hearing, it is determined that the state fails to meet federal requirements, 42 U.S.C. §1396c; see *Rosado v. Wyman,* 397 U.S. 397, 406 n.8 (1970); that drastic sanction, however, is rarely, if ever, invoked. Instead, the Secretary attempts to correct state failures through informal discussion and negotiation. 45 C.F.R. §201.6(c).

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[1]Although many of the policies discussed in this brief were developed by HHS' predecessor, the Department of Health, Education and Welfare ("HEW"), see 20 U.S.C. §3508, references herein will be limited to the designation "HHS". It should be assumed that that expression necessarily refers to "HEW", where chronologically applicable.

Within the confines of the federal statute and regulations, a state has considerable latitude in structuring and administering its program. It is required to provide assistance to the so-called "categorically needy", who are those individuals meeting both a definition of either age, blindness, disability or childhood dependency, and the financial eligibility conditions of the relevant cash assistance program. 42 C.F.R. §435.4. Even so, a state has flexibility in defining the financial eligibility conditions of the categorically needy aged, blind and disabled. It can use the same conditions as are applicable to recipients of Supplemental Security Income ("SSI"), 42 U.S.C. §1381 *et seq.*, the federally-administered and -funded welfare program for the indigent aged, blind and disabled. 42 U.S.C. §1396a(a)(10)(A); 42 C.F.R. §435.120; see *Harris v. McRae, supra,* 100 S.Ct., at 2680 & n.1; *Dawson v. Myers, supra,* 622 F.2d, at 1307 (J.A. 57-58).[2] Alternatively, it can employ more restrictive eligibility conditions, as long as they are no more restrictive than those validly in effect in the state on January 1, 1972. 42 U.S.C. §1396a(f); 42 C.F.R. §435.121; see *Gray Panthers v. Administrator, supra,* 629 F.2d, at 182; *West v. Cole,* 390 F.Supp. 91, 95-99 & nn. 5,6 (N.D.Miss. 1975). Like most states, California did not originally select this

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[2]The SSI program was created in 1972, and went into effect on January 1, 1974. Pub.L. No. 92-603, 86 Stat. 1465. Congress then amended the Medicaid statute to require that Medicaid be automatically available to SSI recipients, as it had been to the recipients of the state-administered cash assistance programs for the aged, blind, and disabled which preceded it. Pub.L. No. 93-233, §13(a)(3), 87 Stat. 960 (1973). See *Gray Panthers v. Administrator, Health Care Financing Administration,* 629 F.2d 180, 182 & n.3 (D.C.Cir. 1980), *pet. for cert. pending sub nom. Harris v. Gray Panthers,* No. 80-756 (filed Nov. 10, 1980); *Caldwell v. Blum,* 621 F.2d 491, 496-497 (2d Cir. 1980), *pet. for cert. pending* No. 79-2034 (filed June 24, 1980).

option, nor has it changed its position; under its state plan, it is therefore required to provide Medicaid pursuant to the SSI eligibility conditions. *Dawson v. Myers,* 622 F.2d, at 1307 n.2 (J.A. 58). Because of its application of the SSI eligibility conditions, California is informally known as an "SSI state".[3]

Regardless of the eligibility conditions that it selects for the categorically needy, a state also has the option of providing Medicaid to an additional class of individuals, known as the "medically needy". They also must meet one of the applicable categorical definitions (i.e., age, blindness, disability, or childhood dependency). They are distinguished from the categorically needy by the fact that their gross income or resources are above the cash assistance levels for eligibility. 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.4; *Beal v. Doe,* 432 U.S. 438, 440 & n.1 (1977); *Dawson v. Myers,* 622 F.2d, at 1307 & n.3 (J.A. 58); *Friedman v. Berger,* 547 F.2d 724, 726 (2d Cir. 1976), *cert. denied* 430 U.S. 984 (1977). They become eligible after incurring medical expenses which reduce their available income below a prescribed level. 42 C.F.R. §435.301; *Dawson v. Myers,* 622 F.2d, at 1307 (J.A. 58). California has opted to extend Medicaid eligibility to the medically needy. Cal.Welf. & Inst.C. §§14005.7, 14051; 22 Cal.Admin.C. §50203; *Dawson v. Myers,* 622 F.2d, at 1307 (J.A. 58).

By statute and regulation, California has implemented its participation in the federal Medicaid program. For what is popularly known as "Medi-Cal", the state has established eligibility standards for participants. These provide, *inter*

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[3]Those choosing the more restrictive approach are generally called "209(b)" or "1972 option" states. See *Gray Panthers v. Administrator, supra,* 629 F.2d, at 182 & n.2.

alia, that the assets of an individual must not be valued over $1500. 22 Cal.Admin.C. §50420. An individual's home and certain other properties, however, are exempt from the resource calculations. 22 Cal.Admin.C. §§50418, 50425-50489. Moreover, even if the applicant or recipient herself resides in a long-term care facility, the home remains exempt for purposes of the resource determination as long as a spouse or other dependent continues to live there. 22 Cal.Admin.C. §50425(a)(4). Furthermore, although no state law has been found to support this practice, the Ninth Circuit has stated that California may recover the cost of medical assistance from an individual's estate after her death. *Dawson v. Myers,* 622 F.2d, at 1308 (J.A. 60); see 42 U.S.C. §1396a(a)(18). This mechanism would apparently be available regardless of whether the property is an exempt resource. See *Fabula v. Buck, supra,* 598 F.2d, at 871.

California also has adopted a "transfer of assets" rule. Cal.Welf. & Inst.C. §14015. It is applicable only to the medically needy, and operates to "prevent[ ] persons from qualifying . . . if they have transferred assets for less than fair consideration within two years prior to their application for assistance." *Dawson v. Myers,* 622 F.2d, at 1307-1308 (J.A. 58-60); see 22 Cal.Admin.C. §50408(b). The fact of a transfer for less than valuable consideration creates a presumption that the transfer was effected in order to obtain eligibility. 22 Cal.Admin.C. §50409. The individual, in theory, is permitted to overcome the presumption, but the "declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption." *Id.,* §50409(b)(2)(A). Moreover, a demonstration that the applicant "did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption." *Id.,*

§50409(b)(2)(B); see *Dawson v. Myers*, 622 F.2d, at 1308 n.5 (J.A. 60). The failure to overcome the presumption results in a denial of eligibility for an unspecified period of time which reflects the actual value of the transferred asset, the estimated cost of care, and the value received for the asset. 22 Cal.Admin.C. §50411.[4]

2. Antonia Beltran is now 88 years old and is expected to require convalescent care for the rest of her life. On February 23, 1977, she and her husband, Leonard, grant-deeded a plot of land in East Los Angeles with two houses on it to their three children. They were living in one of the houses, and they continued to do so after the transfer; one of the children and his family live in the other. Their reason for transferring the property was a long-standing intention to give it to their children when they were no longer capable of taking care of it. Neither of the Beltrans had any knowledge of the resource rules of the Medi-Cal program, nor, at the time, had either one of them sought or obtained Medicaid coverage (R., Tab 14, p.2).[5]

In May, 1977, Antonia Beltran was forced to enter a hospital. When she returned home, a nurse who was helping to care for her arranged an application to California's In-Home Supportive Services program, which provided her with home chore services. At the same time, she and her

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[4]Thus, a transferor who applies more than two years after the date of the transfer will not be subject to section 50409. But an application during that two-year period triggers the presumption and can result in a period of ineligibility substantially greater than two years.

[5]The Record prepared below does not contain consecutively numbered pages, but, rather, utilizes consecutively numbered "Tabs", each of which retains its own pagination. Thus, all references to the Record will be to the appropriate "Tab", and to the page or exhibit within the cited "Tab".

husband were found eligible for the Medi-Cal program. On March 20, 1978, however, she was forced by increasing ill health to move from their house into a nursing home. She required then, and is expected to continue to require for the indefinite future, skilled nursing care. She remained covered by Medi-Cal through August, 1978, when her coverage was terminated. Her husband, however, remained covered. (R., Tab 14, p. 2-3.)[6]

She re-applied on October 27, 1978, but this application was denied on January 8, 1979, specifically because of the February, 1977 transfer of property. (J.A. 49.) The "Notice of Action" informed her that her period of ineligibility would be 885 months, which is slightly over 71 years. (J.A. 6-7, 40; R., Tab 14, Ex. 4.)[7]

Mrs. Beltran's husband, Leonard, continued to live on the property which they had transferred. Because he resided there, the house would have remained an exempt resource for purposes of determining Mrs. Beltran's medically needy eligibility had it not been given away. 22 Cal.Admin.C. §50425(a)(4). Its exempt status, however, did not preclude application of the transfer rule. Moreover, the fact that Mrs. Beltran was not ill when they transferred the property, and the fact that they were not aware of the relevant eligibility conditions at that time, were not considered sufficient to overcome the presumption.

Mrs. Beltran's sole source of income is Social Security

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[6]As near as can be determined, her eligibility for Medi-Cal during this period of May, 1977 through August, 1978, was established without regard to the transfer of property.

[7]Although the record below cannot reflect it, she applied again this year, and was found eligible for Medi-Cal, effective from March 1, 1980. This determination of eligibility was based on a recalculation under the formula set out in 22 Cal.Admin.C. §50411.

benefits. When the summary judgment motion was filed, her monthly check was for $219.80. (R., Tab 14, p. 4.) She paid most of this amount to the nursing facility, but was allowed to keep $45.00 per month for personal needs. Until the redetermination of eligibility, her children paid some of the remaining cost of nursing home care, but a substantial portion remained unpaid (R., Tab 14, p. 4). For the period of ineligibility from September, 1978 through February, 1980, her unpaid bills to the nursing home amounted to nearly $15,000.[8] It is undisputed that, except for appliction of the transfer rule, she would have been found eligible at all relevant times for California's medically needy program, which would have been responsible for the full cost of her care. *Dawson v. Myers,* 622 F.2d, at 1308-1309 (J.A. 61).

3. At the time that Antonia Beltran was denied on re-application in January, 1979, a direct challenge to the transfer rule was then pending in the Central District of California. It had been filed by Rossye Dawson, who had also been denied Medicaid coverage under California's transfer of assets rule. (R. 48.) Antonia Beltran and another individual with the same problem, Enosinsio Manahan, moved to intervene; their complaint-in-intervention was ordered filed on February 26, 1979 (J.A. 2). Beltran and Manahan, like Rossye Dawson, sought declaratory and injunctive relief on behalf of themselves and similarly situated Californians. They alleged that the transfer rule violated federal statutory requirements and Constitutional guarantees. Specifically, they sought to enjoin and invalidate the state's policy of denying or terminating Medi-Cal benefits to those medically needy applicants who had

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[8]The Record, which reflects only the period up to the filing of plaintiffs' summary judgment motion, indicates that by early 1979, her unpaid bills to the nursing home were in excess of $4000 (R., Tab 14, p. 4).

allegedly transferred assets for less than full consideration (J.A. 11).

On May 10, 1979, the district judge granted the motion for class certification (J.A. 45). On the same day, he denied plaintiff's motion for summary judgment, and granted defendants' (J.A. 54-55).[9] The district judge agreed with plaintiffs' contention that a state could not apply more restrictive eligibility conditions to the medically needy than to the categorically needy, but he held that a transfer of assets rule was a "collateral restriction" and a "procedural regulation", not a "substantive eligibility requirement", and that therefore the requirement of equal treatment of the categorically and medically needy was inapplicable (J.A. 51-52).

On appeal, the Ninth Circuit panel agreed with the result reached by the district court, but for different reasons. The court specifically rejected the lower court's characterization of the transfer rule, terming it "a substantive eligibility requirement." *Dawson v. Myers,* 622 F.2d, at 1310 (J.A. 63-64). But the panel concluded that the applicable portion of the Medicaid statute, the so-called "comparability" requirement, 42 U.S.C. § 1396a(a)(10)(C), did not require equal treatment of the two groups of Medicaid applicants. *Id.,* at 1310-1312 (J.A. 64-67).

In doing so, the court effectively held that HHS supported this analysis, id., at 1311 (J.A. 65-66), despite the fact that that agency had started on several occasions that transfer rules could not be applied to the medically needy aged, blind, and disabled in SSI states. (R., Tab 13, Ex. E, F.) Indeed, by letter of September 29, 1978, HHS had informed defendant

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[9]Antonia Beltran and Enosinsio Manahan were the class representatives, as Rossye Dawson had died. *Dawson v. Myers,* 622 F.2d, at 1308 (J.A. 60).

Myers that the state's transfer rule violated federal law (R., Tab 25, Ex. A).

Plaintiffs sought a rehearing, and were supported by HHS, which lodged an amicus brief explicitly contradicting the Court of Appeals' analysis. The Court rejected the request for a rehearing and refused to permit the filing of the HHS amicus brief. (That order is attached as App. C to the Petition for Writ of Certiorari.) By that time, two federal appellate courts, one state appellate court, and two federal district courts had all held, in virtually identical challenges to transfer rules applied against the medically needy in SSI states, that the comparability provisions of the Medicaid statute forbade the use of such rules.[10] In light of the Ninth Circuit's deviation from case authority on the specific issue of this case, and its digression from numerous other decisions upholding comparable treatment of the categorically and medically needy, plaintiff Beltran sought review of that decision.[11]

SUMMARY OF ARGUMENT

A. Aged, blind, and disabled individuals may divest themselves of assets in order to obtain eligibility for SSI benefits. The statute, 42 U.S.C. §1382b(b), and the Social Security Administration Claims Manual, §12507(a),

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[10]*Caldwell v. Blum,* 621 F.2d 491 (2d Cir. 1980), *aff'd* CCH Medicare & Medicaid Guide, ¶30,093 (N.D.N.Y. 1979) (classwide preliminary injunction); *Fabula v. Buck,* 598 F.2d 869 (4th Cir. 1979), *rev'd* 463 F.Supp. 830 (D.Md. 1978); *Robinson v. Pratt,* CCH Medicare & Medicaid Guide, ¶30,605 (D.Mass. 1980); *Scarpuzza v. Blum,* 73 A.D.2d 237, 426 N.Y.S.2d 505 (2d Dept. 1980).

[11]Enosinsio Manahan had died during the pendency of the appeal.

explicitly allow this. In addition, the Medicaid statute establishes that all SSI recipients are automatically eligible for Medicaid as "categorically needy". 42 U.S.C. §1396a(a)(10)(A). These two factors lead to the requirement that, in "SSI" states, categorically needy Medicaid eligibility must be determined without regard to any prior transfer of assets. The regulations reflect this result. 42 C.F.R. §435.120(b).

B. The required equal treatment of the categorically and medically needy leads necesarily to the conclusion that states also cannot apply transfer of assets prohibitions to determine medically needy eligibility.

1. In establishing the Medicaid program, Congress made significant progress in offering states the option of extending benefits to the medically needy whose indigency is caused by high medical costs. A cornerstone of this development was the recognition that, once incurred medical expenses were taken into consideration, the categorically and medically needy were equally impoverished. Consequently, Congress determined to apply the same eligibility conditions to both groups. The statute reflects this intention by requiring eligibility to be determined by "comparable standards", 42 U.S.C. §§1396a(a)(10)(C)(i), 1396a(a)(17), and the legislative history reiterates the congressional recognition for equal treatment of the two groups. See, *e.g.*, S.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2017-2019.

2. In carrying out this goal, the responsible federal agency, HHS, has repeatedly and consistently required states not to discriminate against the medically needy. The regulation applicable to this situation, 42 C.F.R.

§435.401(c), specifically forbids states to use eligibility conditions "more restrictive than those used under SSI . . . ." HHS has expressed its position on comparability in other situations as well. Also, HHS specifically informed California that its transfer of assets rule violated the federal comparability requirements because it was imposed only against the medically needy. Because the HHS evaluation of this issue is long-standing and consistent, it is entitled to considerable deference from the courts.

3. Indeed, while considering various Medicaid issues, the lower courts have regularly agreed that the statute precludes treating the medically needy more restrictively than the categorically needy. On the specific issue of transfer of assets, the Second and Fourth Circuits, a state appellate court in New York, and two federal district courts have all disagreed with the Ninth Circuit and concluded that the comparability requirement precluded states from applying transfer of assets rules to the medically needy. The courts noted, as have Congress and HHS, that there was no rationale for treating one group of indigents differently than another.

4. Furthermore, in reports accompanying several bills proposed over the last three years, Congress has explicitly stated that "present law" forbids states from applying transfer of assets restrictions. See, *e.g.*, H.R.Rep. No. 96-589, part 2, 96th Cong., 2d Sess., 76 (1980). None of these bills has passed. These subsequent legislative observations offer additional confirmation as to existing federal law on this issue.

C. The courts' repeated invalidation of transfer rules has not left the states unprotected. They are permitted to deny Medicaid coverage for up to a year to an applicant who has

attempted to abuse the system, such as by divesting herself of assets in order to obtain eligibility. 42 U.S.C. §1396h(a). Congress' affirmative action in passing this provision, coupled with its repeated decisions not to enact other legislation, indicates that it views the existing approach as the better policy. Examples of how transfer rules unjustly deprive needy people of coverage back this Congressional determination. While many elderly people transfer assets for entirely innocent reasons, the states have repeatedly failed to exercise restraint in applying their divestment provisions. For all of these reasons, the present federal policy is entirely appropriate.

D. That the Ninth Circuit disagrees with this policy is not a sufficient reason for it to substitute its judgment for that of Congress and HHS. Similarly, California may not operate unilaterally. The state does have legitimate options, though. it can attempt to change the federal law. it also may alter its position within the existing Medicaid structure, such as by rejecting the SSI eligibility conditions in favor of "209(b)" status. Dissatisfaction with existing federal policy, however, does not give California the freedom to establish its own eligibility conditions. Its participation in the federal Medicaid scheme and its considerable reimbursement from the federal government require California, like all states, to conform to federal law. That law precludes states from using transfer of assets rules in SSI states.

ARGUMENT

SINCE THE SSI STATUTE PROHIBITS APPLYING TRANSFER OF ASSETS RULES TO SSI APPLICANTS, STATES ARE FORBIDDEN TO CONSIDR TRANSFERS IN DETERMINING ELIGIBILITY OF THE MEDICALLY NEEDY IN "SSI" STATES

A. Transfer rules cannot be applied in SSI states to determine eligiblity for the categorically needy aged, blind and disabled.

It is indisputable that an SSI applicant is permitted to divest herself of assets in order to become eligible for SSI payments. *Dawson v. Myers,* 622 F.2d, at 1310 (J.A. 63); *Caldwell v. Blum,* 621 F.2d, at 494-495; *Fabula v. Buck,* 598 F.2d, at 873; *Scarpuzza v. Blum,* 426 N.Y.S.2d, at 512. The statute specifically permits the Secretary to prescribe the rules applicable to the disposition of assets. 42 U.S.C. § 1382b(b). The administrative interpretation of this statute leaves no doubt that a valid transfer of assets, regardless of the consideration received, is not relevant to the determination of SSI eligibility.

> "The valid disposal or transfer, as by sale or gift, of a resource prior to the filing of an SSI program application, does not preclude eligibility for payment, even though retention of the resource would have placed an individual's or couple's resources over the applicable limit. This is true with respect to cash and real or personal property and also true though the resource may have been given as a gift or sold for less than its market value to a relative or friend." Social Security Administration Claims Manual, § 12507(a) (App. D to Petition for Certiorari, at 37).

Indeed, the Manual expressly recognizes that the effort to divest may be intended "for the purpose of being within the applicable limits. . . ." *Ibid.* In effect, as long as the transfer is valid, it is of no consequence for SSI eligibility why the property is transferred.

It then automatically follows that no transfer rule may be applied to determine the Medicaid eligibility of SSI applicants and recipients. This is so because, as has been previously noted, the SSI states are required to determine Medicaid eligibility for the categorically needy using the same rules as are employed in determining SSI eligibility. The Medicaid statute requires this identical treatment, as it demands that all those eligible for SSI be covered under Medicaid. 42 U.S.C. § 1396a(a)(10)(A). The courts agree that this is the statute's correct interpretation.[12] And, lest any doubt exist, the regulations require states to provide Medicaid to those SSI recipients who have disposed of assets. 42 C.F.R. § 435.120(b).

Neither the defendants below, nor any of the courts which have considered the transfer issue, have suggested otherwise. The point of departure, therefore, must be that California may not apply a transfer of assets rule to its aged, blind, and disabled applicants for categorically needy Medicaid coverage.

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[12]See, *e.g., Harris v. McRae, supra,* 100 S.Ct., at 2680 n.1; *Beal v. Doe, supra,* 432 U.S., at 440 n.1; *Blum v. Caldwell,* — U.S. — , 100 S.Ct. 1635, 1637 (Mr. Justice Marshall, in chambers, 1980); *Caldwell v. Blum,* 621 F.2d, at 494. But see *Herweg v. Ray,* 619 F.2d 1265, 1272-1274 (8th Cir. 1980), *pet. for cert. pending* No. 80-60 (filed July 14, 1980) (evenly divided *en banc* court upholding district court determination that Iowa, an SSI state, need not follow certain HHS Medicaid regulations premised on SSI rules).

B. The "comparability" requirements of the Medicaid statute preclude applying more restrictive rules to the medically needy than to the categorically needy.

1. One of the most significant advances in Title XIX was the effort to extend coverage to those whose poverty was caused by high medical costs. States were given the option of providing medical care not only to those who were indigent by any standard, but also to those who were medically indigent, that is, forced to choose between medical care and other necessities.

To accomplish this goal, Congress established a flexible system for determining eligibility. It created a "spend-down" mechanism, by which the applicant whose gross income and resources were over the eligibility levels became eligible for Medicaid once her actual income and resources had been reduced to the established level of indigency by necessary medical costs. A state had to "be sure that the income of the individual has been measured in terms of both the state's allowance for basic needs and the cost of the medical care he requires." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2019 (1965).

Congress logically determined that this group should have their poverty evaluated at the same levels and by the same procedures as did those whose eligibility was established without considering medical costs. Indeed, it would have been extremely cynical to recognize the precarious position of the medically indigent, and then premise their eligibility on standards more restrictive than those applicable to the categorically needy. The legislature's concern that the medically needy be treated no differently than the cate-

gorically needy is reflected in this passage from the Senate Finance Committee report:

> "In no event, however, with respect to either the [medically needy spend-down] provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income and resources which would bring the individual's income below the amount established as a test of eligibility under the State plan. Such action would reduce the individual below the level determined by the state as necessary for his maintenance." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2019.

In short, common sense dictated that if the medically needy were entitled to coverage, states had to recognize that once medical expenses were considered, they were just as impoverished as the categorically needy.

The decision to utilize equivalent eligibility standards is initially reflected in the provision identifying the medically needy. It permits states to provide assistance to

> "all individuals who would, except for income and resources, be eligible . . . to have paid with respect to them supplemental security income benefits and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services. . . ." 42 U.S.C. § 1396a(a)(10)(C)(i).[13]

The provision first identifies the medically needy. They are those who, except for having income or resources over the

[13]This provision was originally codified as 42 U.S.C. § 1396a(a)(10)(B). 79 Stat. 345 (1965). A 1973 amendment, Pub. L. 93-233, § 13(a)(3), 87 Stat. 960, recodified and slightly reworded the provision as 42 U.S.C. § 1396a(a)(10)(C). The spend-down and comparability provisions were not altered.

eligibility levels, would be eligible for cash assistance. Thus, although they meet the categorical definition of age, blindness, or disability, their greater gross income or resources renders them ineligible for cash assistance. The recognition of this similarity between cash assistance recipients and those with income and resources over the cash assistance levels leads to the requirement of comparability in the next section of the provision. As the only difference between the groups is the greater gross income and resources of the medically needy, they become, for all relevant purposes, indistinguishable when those amounts are reduced to the poverty level by medical costs. Consequently, it is appropriate that comparable standards be applied to them.[14]

Congress' concern that one classification of eligibles not be discriminated against is further reflected in the general eligibility section, 42 U.S.C. §1396a(a)(17). It requires states to "include reasonable standards (which shall be comparable for all groups. . . .)" This section thus reinforces the legislative goal that once a group is recognized as eligible for Medicaid, states cannot apply discriminatory standards against it.

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[14]The Ninth Circuit's discussion of this section, 622 F.2d, at 1310-1311 (J.A. 64), is unique in both case law and agency interpretation. While recognizing that the section does extend all of the SSI conditions to the medically needy, the court concludes that the reference is only to non-financial conditions of eligibility. The court states that "[w]ere this not the case, then there would be no distinction between the two groups." *Id.*, at 1310-1311 (J.A. 64). The distinction between the categorically and medically needy, though, is defined by the "except for" clause: the latter have larger gross incomes and resources than the former. If the analysis of the court below were correct, there would be no limits on minimum eligibility conditions imposed by the states on the medically needy.

The discussion of these provisions in the legislative history reiterates the Congressional concern for equality of treatment between the medically and categorically needy. Thus, the Senate Finance Committee Report notes that

> "if a state extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2017.

That Report also includes this discussion requiring equal treatment:

> "Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) . . . would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him." *Id.*, at 2018.

2. Comparability, thus, was an important and much-considered aspect of the Medicaid statute. Congress was generally concerned that states not be permitted to treat one group of eligibles different than another. The statute reflects that concern. The Ninth Circuit has suggested, however, that "comparable standards" may be defined, in effect, to include contradictory eligibility requirements. *Dawson v. Myers,* 622 F.2d, at 1311 (J.A. 64, 65). If any vagueness does not attach to the word "comparable", though, the responsible federal agency has expressly and repeatedly clarified its

meaning. HHS has recognized through the years that Congress sought to avoid discriminatory treatment of the medically needy. The applicable present regulation spells this out simply and conclusively:

> "(c) The [state] agency must not use requirements for determining eligibility for optional coverage groups that are. . .
>
> (2) for aged, blind, or disabled individuals, more restrictive than those used under SSI. . . ."

42 C.F.R. §435.401(c).

The regulations further note that a state may employ *higher* eligibility levels for the medically needy, 42 C.F.R. §§435.812, .840, but it is precluded from using more restrictive conditions.

Section 435.401(c) was first promulgated by HEW in 1974. Although its numbering and wording have changed, the meaning and intent have never been altered.[15] The agency has consistently required that the medically needy not be treated more restrictively than the categorically needy, and regulations relevant to other aspects of comparability further reflect this long-standing policy.[16]

Furthermore, in comments to regulations which sought to

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[15]The original section was 45 C.F.R. §248.2(b) (2). 39 Fed.Reg. 9515 (1974). A renumbering of regulations rendered it 42 C.F.R. §448.2(b) (2). 42 Fed.Reg. 52827 (1977). A year later, it was reworded and recodified in its present form. 43Fed.Reg. 45204 (1978). See *Caldwell,* 621 F.2d, at 497 n.8. Although the wording was altered, HHS specifically noted in its introduction that "[n]o policy changes have been made in the eixsting regulations" and that there were "[n]o substantive changes". 43 Fed.Reg. 45176. This is significant, as there was some confusion arising from the previous wording of the regulation. See *Fabula v. Solomon, supra,* 463 F.Supp., at 836. The 1978 rewording, however, leaves no doubt that states could not use more restrictive eligibility conditions, and this has always been HHS policy.

[16]See, *e.g.,* 42 C.F.R. §§435.812, .831(a), .840.

integrate certain SSI eligibility conditions into state Medicaid standards, HHS explained its comprehension of the statutory requirement for no more stringent eligibility conditions for the medically needy:

> "Section 1902a(10)(C)(i)[42 U.S.C. §1396a(a)(10)(C)(i)] goes on to state that where a State covers other aged, blind and disabled persons all SSI eligibility criteria must be applied '. . . except for income and resources. . .'. This means that while a state might use more generous maintenance amounts in determining financial eligibility . . ., all other SSI eligibility criteria are to be used.
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> * * *
>
> [A]ll aged, blind and disabled persons applying in States covering all SSI eligibles must have their eligibility determined using all SSI eligibility rules except for — and only except for — higher dollar amounts for income and resource eligibility levels." 42 Fed. Reg. 2684 (1977).

This discussion provides a comprehensive explanation of the proper interpretation of the statute. The medically needy can, if a state so desires, have higher eligibility levels, but the state must, at a minimum, set those standards no lower than the SSI levels. A state is forbidden to use more restrictive conditions.

Although those pronouncements would appear clear-cut and not subject to conflicting interpretations, the agency also sent out a specific explanation as to the applicability of these requirements in the divestment context. After reviewing the relevant statutes and regulations, HHS concluded:

> "Since transfer of property restrictions are not imposed under the SSI program, [SSI] states may not deny Medicaid eligibility to aged, blind and disabled persons who have transferred property prior to applying as categorically needy.

* * *

> With respect to the medically needy, [the applicable regulations] require that coverage of the medically needy must correspond to categorically needy coverage available under the state's plan (i.e., eligibility conditions imposed on the medically needy cannot be more restrictive than the conditions for eligibility as categorically needy) . . . . Thus, transfer of property restrictions cannot be imposed on the medically needy unless comparable restrictions are imposed on the categorically needy . . . ." HCFA [Health Care Financing Administration of HHS] Regional Office Manual, Part 6, Medicaid Guidelines, Transmittal No. 31 (June 19, 1979), reprinted in CCH Medicaire & Medicaid Guide, ¶ 30,392.

Perhaps most significant, however, is that the federal agency's view on this matter has been explicitly presented to the defendants. In his letter of September 29, 1978, Lawrence McDonough, the Regional Medicaid Director, who represents the Secretary for the region in which California is located,[17] informed defendant Myers of California's non-compliance:

> "[A] 'transfer of property' restriction may not be imposed upon SSI recipients for purposes of determining Medicaid eligibility since such a restriction is not permitted for SSI eligibility purposes. Accordingly, a State that chooses the above-referenced option would not be fulfilling its obligation to make Medicaid assistance available to all SSI recipients (as required by [42 U.S.C. §1396a(a) (10) (A)] if it imposed a 'transfer of property' restriction. Absent such a restriction on the categorically needy, [42 U.S.C. §1396a(a) (10) (C) (i)] precludes imposition of a 'transfer of property' restriction on the corresponding group of the medically needy in the State's Title XIX program." (R. Tab 25, Ex. A, 21-22.)

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[17]See Statement of Organization, Function, and Delegation of Authority, 42 Fed.Reg. 33071, 33093 (1977).

Similar expressions of non-compliance from Regional Directors were sent to state officials in New York and Michigan, and a further explanation of HHS' position was provided to plaintiffs' attorneys in this case (R. Tab 14, Ex. C, E, F). See *Caldwell,* 621 F.2d, at 495; *Fabula,* 598 F.2d, at 873 n.10; *Scarpuzza,* 426 N.Y.S.2d, at 513 & n.19. Moreover, HHS lodged an amicus brief with the Ninth Circuit supporting plaintiffs' request for a rehearing, in which it restated its agreement with plaintiffs' position. It must therefore be beyond serious dispute that HHS views California's transfer rule as violative of federal law.[18]

Thus, any uncertainty as to the meaning of the comparability provision has been resolved by the responsible federal agency. HHS' approach to this problem has never changed course, and follows that of the courts which have considered it. See, *e.g., Caldwell,* 621 F.2d, at 497 n.8. It is well established that an agency's "consistent, long-standing interpretation of the statute under which it operates is entitled to considerable weight." *International Brotherhood of Teamsters v. Daniels,* 439 U.S. 551, 566 n.20 (1979); *New York State Department of Social Services v. Dublino,* 413 U.S. 405, 421 (1973); *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381 (1969). This is not an instance in which the agency has published contradictory or unclear positions, or contravened clear Congressional

[18]The Ninth Circuit's attempt to ignore the position of HHS, 622 F.2d, at 1311 (J.A. 66), represents a misperception of how that agency is structured. The Regional Directors speak for the Secretary, not contrary to her. The other courts considering this issue all recognized the significance of the regional determinations. *Caldwell,* 621 F.2d, at 495; *Fabula,* 598 F.2d, at 873 n.10; *Scarpuzza,* 426 N.Y.S.2d, at 513 n.19. Furthermore, the decision to seek compliance without a formal hearing is standard HHS policy. See 45 C.F.R. § 201.6(c). The radical sanction of a termination of funds is rarely employed.

intent. See, *e.g., Esponoza v. Farah Manufacturing Co.,* 414 U.S. 86, 94-95 (1973). Indeed, the agency interpretation directly follows from the provisions enacted by Congress. As the Fourth Circuit succinctly noted when considering the same issue: "[T]hese administrative interpretations are reasonable and consistent with the statute, and are entitled to be followed by the courts." *Fabula v. Buck,* 598 F.2d, at 873. See also *Miller v. Yoakim,* 440 U.S. 125, 144 & n.25 (1979); *Caldwell,* 621 F.2d, 497; *Scarpuzza,* 426 N.Y.S.2d, at 513.

3. HHS' position on comparability is not a unique one. Indeed, the policy which this position effects has long been accepted and implemented by courts around the country. Except for the Ninth Circuit, there is no extant decision which allows for discrimination against the medically needy. The courts have regularly concluded that the statute requires states not to apply more restrictive conditions to the medically needy.

The list of cases which counter the analysis of the Ninth Circuit is itself an indication of the impropriety of that

Court's decision.[19] These decisions, which are concerned with various aspects of comparability between the categorically and medically needy, corroborate HHS' effort to carry out the intent of Congress. They recognize, implicitly and explicitly, that while Congress gave the states the option of including a medically needy program, it did not intend that those states selecting that option would act maliciously towards the medically needy. As one court noted in upholding a federal regulation requiring equal treatment:

> "To discriminate against the self-supporting by requiring them to live on income below the level declared by New York to be necessary for minimal maintenance would do violence to the aims of the Medicaid legislation and common sense . . . [I]t remains deep and

[19] *Caldwell v. Blum,* 621 F.2d 491 (2d Cir. 1980), *aff'd* CCH Medicare & Medicaid Guide ¶ 30,093 (N.D.N.Y. 1979); *Fabula v. Buck,* 598 F.2d 869 (4th Cir. 1979), *rev'g on this point,* 463 F. Supp. 830 (D.Md. 1978); *Greklek v. Toia,* 565 F.2d 1259, 1261 (2d Cir. 1977), *cert. denied sub nom. Blum v. Toomey,* 436 U.S. 962 (1978); *Friedman v. Berger,* 547 F.2d 724, 729 (2d Cir. 1976), *cert. denied* 430 U.S. 984 (1977); *Robinson v. Pratt,* CCH Medicare & Medicaid Guide, ¶ 30,605 (D.Mass. 1980); *Winter v. Quern,* 490 F.Supp. 788, 792-793 (N.D.Ill. 1980), previous opinion on same point *sub nom. Winter v. Trainor,* CCH Medicare & Medicaid Guide, ¶ 28,151 at 10,599 (N.D.Ill. 1977); *Hendrickson v. Noot,* CCH Medicare & Medicaid Guide, ¶ 30,499, at 9920 (D.Minn. 1980); *Dawson v. Beach,* No. 78-2350, Slip Op., at 7 (C.D.Cal. 1979) (J.A. 51); *Schultz v. Noot,* Civ. No. 4-79-334, Slip Op., at 8 (D.Minn. 1979); *Aitchison v. Berger,* 404 F.Supp. 1137, 1149 (S.D.N.Y. 1975), *aff'd without opinion* 538 F.2d 307 (2d Cir.), *cert. denied* 429 U.S. 890 (1976); *Dominquez v. Milliken,* CCH medicare & Medicaid Guide, ¶ 26,633, at 9221 (W.D.Mich. 1973); *Schaak v. Schmidt,* 344 F.Supp. 99, 103-104 (E.D.Wis. 1971); *Scarpuzza v. Blum,* 73 A.D.2d 237, 426 N.Y.S. 505 (2d Dept. 1980); *Wong v. Brian,* CCH Medicare & Medicaid Guide, ¶ 26,605 at 9014-9015 (Cal.Ct.Ap.1972). See also *Blum v. Caldwell, supra,* 100 S.Ct., at 1637.

> familiar in our esteem for individual initiative that we would not deem it acceptable without some particular justification to treat those outrside categorical assistance groups less generously than those within. The questioned regulation . . . reflects this philosophy. No good reason appears . . . for . . . holding it invalid." *Aitchison v. Berger, supra,* 404 F.Supp., at 1149-1150 (footnote omitted).

It is no wonder, then, that the Fourth Circuit could not fathom how Maryland could rationally support a divestment rule applicable only to one class of eligibles: "[W]e question how the transfers made by plaintiffs, which would be expressly permitted under SSI guidelines, can be fraudulent acts under the Medicaid program simply because they are performed by the medically needy rather than by an SSI recipient." *Fabula,* 598 F.2d, at 874 (footnote omitted).

In short, the courts have grasped, regularly and virtually without dissent, that common sense and basic justice require treating these two groups the same. Once the income and resources of the medically needy have been reduced to poverty levels by medical expenditures, there is no rationale for different treatment.

4. Additional support that the interpretation of HHS and the courts is the correct one has been recently and repeatedly provided by Congress. In the last three sessions, several bills have been introduced which would have explicitly authorized states to impose some restrictions on what property could be transferred and when. The proponents of these bills undertook these efforts because of Congress' understanding that such rules were not now permissible, as the legislative histories of these proposals indicate. Thus, the Senate Finance Committee made this observation concerning section 21 of H.R. 5285: "Under present law, States which use the SSI criteria in determining Medicaid eligibility for

the aged, blind, and disabled may not impose transfer of assets restrictions on those applicants . . . ." S.Rep.No. 95-1111, 95th Cong., 2d Sess., 24 (1978).

This bill did not pass, but another one, H.R. 934, was proposed. Again, according to the Senate Report, the suggested prohibition would have allowed states to impose restrictions which they are not now permitted to employ. See S.Rep.No. 96-471, 96th Cong., 1st Sess., 48 (1979), quoted in *Caldwell,* 621 F.2d, at 497 n.6. Senate bills which also would have permitted limited restrictions on divestment, S. 505, §24, and 5.507, §13, were accompanied by similar evaluations. Senate Finance Committee Press Release No. H-18 (March 22, 1979), reprinted in CCH Medicare & Medicaid Guide, ¶ 29,592, at 9813. None of these became law. And, similar legislation was proposed this session, H.R. 4000, §31; it also recognized the existing law on this issue:

> "[S]ince there is no prohibition against transfer of assets in the SSI program under current law, a State which does not restrict eligibility of title XVI [SSI] beneficiaries may not impose such a restriction on Medicaid eligibility for any other aged, blind or disabled person." H.R.Rep.No. 96-589, part 2, 96th Cong., 2d Sess., 76 (1980).[20]

Congress has thus explicitly recognized that its requirement of identical treatment of the categorically and medically needy precludes applying transfer rules to the medically needy. Subsequent Congressional comments tend

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[20]Furthermore, proponents of transfer restrictions included one in each of the reconciliation bills proposed this session. S. 2885, §511; H.R. 7765, §333. Both of these provisions, however, were deleted from the final version by the conferees; that version has been passed and signed into law as the Omnibus Reconciliation Act of 1980, Pub.L. 96-499. See 126 Cong.Rec. H11687-H11703 (daily ed., Dec. 3, 1980); 126 Cong.Rec. §15335-§15355 (daily ed., Dec. 3, 1980).

to confirm apparent legislative intent, *New York State Department of Social Services v. Dublino, supra,* 413 U.S., at 416 n.19; *Banco Nacional de Cuba v. Farr,* 383 F.2d 166, 175 (2d Cir. 1967), *cert. denied* 390 U.S. 956 (1968), and this is especially true where, as here, Congress has repeatedly observed the contemporary state of the law. This is not merely an instance in which legislative intent must be inferred from Congressional inaction, but, rather, one in which a later Congress explicitly recognizes the contribution of a prior Congress. The meaning and import of the statute has thus been fully clarified by present legislators. *Caldwell,* 621 F.2d, at 497-498. For Congress, therefore, as well as for the responsible federal agency and nearly all courts considering the matter, the comparability provisions prohibit states from applying divestment rules against the medically needy in SSI states.

C. The federal prohibition against transfer rules reflects a policy decision that these rules are inappropriate.

In the last five years, courts have repeatedly struck down transfer of assets rules for a variety of reasons.[21] This has taken place in the face of claims that transfer rules are necessary to preserve state resources for those who are "truly" in need. See *Dawson v. Myers,* 622 F.2d, at 1315 (J.A. 72). The Medicaid statute, though, does not leave states at the mercy of unscrupulous individuals, as the states suggest. It provides for both criminal and civil punishment of

[21] *Caldwell; Fabula; Scarpuzza; Caldwell v. Blum* ("*Caldwell II*"), No. 78-CV-569 (N.D.N.Y., Nov. 4, 1980); *Udina v. Walsh,* 440 F.Supp. 1151 (E.D.Mo. 1977); *Buckner v. Maher,* 424 F.Supp. 366 (D.Conn. 1976), *aff'd* 434 U.S. 898 (1977); *Owens v. Roberts,* 377 F.Supp. 45 (M.D.Fla.1974).

recipients who engage in certain activities, including improper divestment to obtain eligibility. 42 U.S.C. §1396h(a); see *Fabula v. Buck,* 598 F.2d, at 874. That provision specifically sets out the sanctions available to the state. After a conviction, the individual may be deprived of Medicaid eligibility for up to a year. In the absence of a conviction, though, Congress has apparently concluded that states may not make their own determination to deprive an eligible individual of benefits. *Id.*, at 874. Since the federal government pays at least half the cost of Medicaid in every state, see 44 Fed. Reg. 10553 (1979), it is appropriate that it prevent states from unilaterally applying biased rules which deny coverage to eligible applicants. The federal measure gives states an appropriate tool, and represents a legislative determination that the less finely tuned state efforts are not permissible.

Congress has now repeatedly failed to enact legislation authorizing states to restrict transfers. It could be contended that this consistent refusal to act is due to factors irrelevant to the pros and cons of transfer rules. Still, when Congress does not respond to a situation regularly brought to its attention and taken into consideration, Congressional acquiescence in the existing law can be inferred. *Power Reactor Development Co. v. International Union of Electrical, Radio and Machine Workers, AFL-CIO,* 367 U.S. 396, 408-409 (1961). Given the considerable harm caused by these rules, and their unjust application, it is apparent that Congress, as a body, has determined that the present federal scheme on this issue is the proper one.

It is not here suggested that abuses donot and will not take place. Those abuses, however, are and can be resolved via the existing mechanism in the Medicaid statute. The method utilized by California, and by other states, cuts much too

broad a path, inevitably denying coverage to far too many of the innocent. The states repeatedly demonstrate an inability to refrain from overreacting to alleged abuses by claimants. While, in theory, it might be possible to distinguish fairly and consistently between innocent transferors and those with questionable motives, in practice, transfer rules are applied too strictly and with no sense of common fairness. A few examples demonstrate the inadequacies of these rules, and indicate why their prohibition is the preferred policy.

The representative plaintiff, Antonia Beltran, was denied eligibility despite a number of factors which strongly suggest that she had no intent to defraud. She was not ill at the time of the transfer. She was 86 years old before she first applied for Medicaid — and then only at the suggestion of a nurse (R. Tab 14, p. 2-3). She was not aware of the eligibility conditions when the property was deeded to her children. (R. Tab 14, p. 2.) She and her husband had intended to give it to them all along, and waited until they themselves were no longer capable of taking care of it. (R. Tab 14, p. 2.) Still, the County of Los Angeles concluded that she had not overcome the presumption, and established an unconscionable period of eligibility.

Enosinsio Manahan, who died while this case was pending before the Court of Appeals, presents a harsher example. In May, 1977, three months after he entered a nursing home, his wife sold their house to pay off various debts. He was not legally competent to participate in the disposition of the property (J.A. 25), but Orange County still found him ineligible because of his community property interest in the proceeds of the sale. The hearing officer who reversed this decision noted that Mr. Manahan's mental condition was such that he "lacked a mental capacity to transact legal business." Proposed Decision (J.A. 25). The

defendants, however, overruled the hearing officer, concluding that he had not overcome the presumption: his wife "acted in his behalf." "[T]he fact that [she] . . . made the transfer of property does not absolve the claimant of this action." Decision of the Director (J.A. 37).

Similar decisions appear to be the rule in California, which is not surprising given the nature of the presumption against the claimant.[22] State heavy-handedness, however, is not limited to California. In Massachusetts, another individual with a severe mental impairment lost Medicaid eligibility when his wife, without his knowledge, gave away money from their joint account. *Robinson v. Pratt, supra,* CCH Medicare & Medicaid Guide, ¶ 30,605, at 10,481-10, 482. Ironically, since his wife was an SSI recipient, she was not disqualified for Medicaid assistance. As the court observed: "Mr. Sweeney's case not only represents a harsh application of the rule, but also dramatically demonstrates the unequal treatment of which the plaintiff complains." *Id.*, at 10,481.

In New York, a long-time recipient of Medicaid and SSI transferred her house to a family member in January, 1978. Because she was an SSI recipient, she continued to receive benefits under both programs. Unfortunately, she was forced

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[22]Once the fact of the transfer is established, the claimant can only overcome the presumption that the transfer was made in order to obtain eligibility by "establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct." 22 Cal.Admin.C. §50409(b) (2). Proof that the applicant transferred in order to avoid probate, or that the applicant had no knowledge of Medi-Cal, are specifically cited as insufficient to overcome the presumption. *Id.*, at §50409(b) (2) (A), (B). With this burden, which effectively precludes an individual from testifying as to her intent, it is the rare person indeed who can demonstrate that she did not set out to obtain eligibility.

to enter a skilled nursing facility the following September, with the result that she lost her SSI eligibility.[23] Of course, once that happened, she lost her categorically needy Medicaid eligibility, and was then denied medically needy coverage because of the tansfer. *Caldwell v. Blum, supra,* CCH Medicare & Medicaid Guide, ¶ 30,093, at 9739. The fact that she was eligible in one context, but not in the other, for precisely the same act, is starkly demonstrative of the irrationality of different treatment.[24]

Examples of this kind do not represent extremes.[25] Indeed, many people, especially the elderly, give away their property, for a variety of reasons. Most have no desire to

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[23]The SSI eligibility level in an institution certified for Medicaid coverage is $25 per month. 42 U.S.C. §1382(e) (1) (B); 20 C.F.R. §416.231(a) (2). Consequently, most nursing home residents are dependent on the medically needy spend-down to be eligible for Medicaid.

[24]These situations further support the Congressional recognition that the categorically and medically needy are two sides of the same coin. An institutionalized individual who is denied Medicaid as medically needy is often forced to move to an uncertified home — if indeed she can find even that. Rossye Dawson, the original plaintiff in this case, had to take this route (R. Tab 2). Because that home is not certified by the state, and is not eligible to receive Medicaid payments, the individual's SSI eligibility level reverts to the normal amount. The claimant is then eligible for SSI, and, of course, is automatically covered by Medicaid. If she tried to move to a certified home, however, the cycle would start again.

[25]See, *e.g., Anson v. Kitchin,* 64 A.D.2d 752, 406 N.Y.S.2d 916 (3d Dept. 1978) (welfare department views payment of outstanding credit card bill, while claimant was in the hospital believing that he was dying, as improper transfer of assets); *Gardner v. Lavine,* 56 A.D.2d 930, 393 N.Y.S.2d 51 (2d Dept. 1977) (welfare department views payment of debt after individual was hospitalized for gunshot wounds as improper transfer even though he had unsuccessfully attempted to pay the debt two years prior to his hospitalization).

defraud the Medicaid program. They seek to avoid probate problems and costs; they may want to give their children an opportunity to use the property immediately, rather than forcing them to wait for their deaths. They may be incapable of taking care of real property, and want to ensure that it does not fall into disrepair. In many, probably most, instances, the elderly person is not even aware of the existence of Medicaid.[26] Yet, under the California regulation, ignorance of the program is not a relevant factor in determining the applicant's intent. 22 Cal.Admin.C. §50409(b)(2). Furthermore, as the examples indicate, however the rules are written, they are inevitably applied in the most restrictive possible manner.

D. While California has many options, its participation in the federal medicaid program precludes it from employing a provision which violates federal law.

Congress has determined that the medically needy should be treated no more restrictively than the categorically needy.

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[26]It is a common mistake, for instance, for the public in general, and the elderly in particular, to confuse the Medicaid and Medicare programs. The latter, Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, is a federally-administered insurance program, tied to Social Security taxes. See generally *Mathews v. Diaz*, 426 U.S. 67, 70 n.1 (1976). Although it nominally covers skilled nursing home care, 42 U.S.C. §1395d(a)(2), Medicare is not, in practice, a significant factor in nursing home expenditures. Indeed, a recent Report by the House Select Committee on Aging notes that only 1.5% of nursing home care is paid for out of Medicare funds. Comm.Pub.No. 96-245, 96th Cong., 2d Sess., 22 (1980). But few are aware of this *de facto* noncoverage by medicare, and it is doubtful that many people know that nursing home care will have to be paid for by a state's Medicaid program.

The responsible federal agency has effected this goal with specific regulations and interpretative material, and has consistently followed this position. With the exception of the decision below, the courts have agreed that this is a reasonable and proper interpretation of the law. Later Congresses have explicitly recognized this position, and have not changed it. These factors all strongly favor a decision by this Court to the same effect. *Blue Chip Stamps v. Manor Drug Stores,* 421 U.S. 723, 733 (1975).

By contrast, there is no support for the position of the court below. Its analysis indicates a concern with policy, rather than with established law. While a court is free to express disagreement with the policy that a federal law represents, it may not substitute its preference for that of Congress and the responsible federal agency. " '[I]ssues of legislative policy . . . [are] better addressed to the wisdom of Congress than to the judgment of this Court.' " *Miller v. Youakim, supra,* 440 U.S., at 142 n.21, quoting *Marquette National Bank v. First of Omaha Service Corp.,* 439 U.S. 299, 319 (1978). California, of course, has that ability: if state officials are dissatisfied with a federal law which precludes them from carrying out what they believe is the better policy, then "it is the legislative branch to which appeals for modification must be directed." *Philbrook v. Glodgett,* 421 U.S. 707, 719 (1975).

The state has other options, as well, which are built into the Medicaid program and which therefore are not dependent on the cooperation of federal legislators. It can eliminate its medically needy program at any time. While plaintiff certainly does not favor that approach, it is legally available to the state. Also available, and with less drastic effect on recipients, is a shift in the basis of eligibility for the aged, blind, and disabled to the "209(b)" option. New York,

for instance, has just made this move.[27] "Freeing" itself from the SSI eligibility conditions may provide California with the flexibility which it desires.

In short, California is not forever tied to one set of eligibility standards for its Medi-Cal recipients. The statute has provided the states with various options. The state cannot claim that reversal of the lower court in this case will spell doom for its fiscal position.

The federal law for the SSI states on the transfer of assets issue is well settled. It represents the established and repeated determinations of the federal legislature, the responsible agency, and virtually all reviewing courts. Although California may disagree with that policy, it may not select its own course as long as it continues to participate in the cooperative scheme of Medicaid. It has options, but establishing conditions directly opposite to those of the Social Security Act is not one of them. As long as the state accepts federal funds, it must conform with the requirements of federal law. California's transfer of assets rule conflicts with that law, and should be invalidated.

CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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[27]See "*Caldwell II*", *supra*, Slip Op., at 9.

No. 80-5303
IN THE

Supreme Court of the United States

October Term, 1980

ANTONIA BELTRAN, individually and on behalf of all others similarly situated,

Petitioner,

vs.

BEVERLEE A. MYERS, individually and as Director, California State Department of Health; and ELISABETH LYMAN, individually and as Deputy Director, California State Department of Health,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit.

BRIEF OF RESPONDENTS.

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No. 80-5303
IN THE

Supreme Court of the United States

October Term, 1980

ANTONIA BELTRAN, individually and on behalf of all others similarly situated,

Petitioner,

vs.

BEVERLEE A. MYERS, individually and as Director, California State Department of Health; and ELISABETH LYMAN, individually and as Deputy Director, California State Department of Health,[1]

Respondents.

BRIEF FOR RESPONDENTS.

Statement of the Case.

1. In 1965, Medicaid was established under Title XIX of the Social Security Act. (42 U.S.C. sec. 1396 et seq.) Its purpose was to enable each state ". . . as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose

[1]Beverlee A. Myers is the Director of the Department of Health Services, which is erroneously identified in the caption as its predecessor, the Department of Health; Elisabeth Lyman is the Deputy Director of the Department of Health Services, which is also erroneously identified as the Department of Health.

income and resources are insufficient to meet the costs of necessary medical services. . . ." (42 U.S.C. sec. 1396.) This cooperative federal-state program is designed to provide medical assistance only to those individuals who truly are in need of such assistance. A state that elects to participate in the program is required to adopt a state plan for assistance which conforms to federal law. (42 U.S.C. sec. 1396a(b).) Once a state plan is approved by the Secretary of the Department of Health and Human Services (HHS),[2] the state is eligible to receive federal financial assistance for its program. (42 U.S.C. sec. 1396.)

One requirement of federal law binding upon a state which operates a Medicaid program is that it must provide coverage to a group of persons known as the "categorically needy"—primarily those individuals who receive financial assistance under Title IV-A of the Social Security Act (Aid to Families with Dependent Children, referred to as "AFDC") or Title XVI of the Social Security Act (Supplemental Security Income for the Aged, Blind, and Disabled, referred to as "SSI"). (42 U.S.C. sec. 1396a(a)(10)(A); 42 C.F.R. sec. 435.4.) States also have the option of covering a group of individuals known as the "medically needy"—primarily those individuals who would qualify for Title IV-A or Title XVI financial assistance except that they have sufficient income and resources to cover their needs, apart from medical expenses. (42 U.S.C. sec. 1396a(a)(10)(C); 42 C.F.R. sec. 435.4.)

2. California has chosen to participate in the Medicaid program. (J.A. 58.) California's state plan for medical as-

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[2]While many of the policies discussed in this brief were developed by HHS' predecessor, the Department of Health, Education and Welfare (20 U.S.C. sec. 3508), references herein will be limited to the designation "HHS."

sistance (referred to as the "Medi-Cal program") was approved by the Secretary and the state is presently receiving federal funds. (J.A. 66.) California has enacted a comprehensive body of statutes and promulgated regulations to administer its Medi-Cal program. (Welf. & Inst. Code sec. 14000 et seq.; 22 Cal. Admin. Code sec. 50000 et seq.) As part of that program, California has elected to cover the optional medically needy. (Welf. & Inst. Code secs. 14005.7, 14051; J.A. 58.)

In 1965, California adopted Welfare and Institutions Code section 14015. This statute and the regulations promulgated thereunder (22 Cal. Admin. Code secs. 50408, 50409) comprise what is called the "transfer of assets rule." The transfer rule creates a rebuttable presumption that any transfer of assets for less than adequate consideration within two years prior to applying for assistance was made with the intent to qualify for medical assistance. The applicant has the opportunity to rebut the presumption by providing evidence ". . . that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources." (22 Cal. Admin. Code sec. 50409.) Failure to rebut the presumption will result in ineligibility for medical assistance for a specified period of time. (22 Cal. Admin. Code sec. 50411.) Because the Social Security Administration does not utilize a transfer of assets rule in determining eligibility for Title XVI cash assistance (Social Security Administration Claims Manual, sec. 12507(a)), the transfer rule is not applied to the SSI categorically needy.[3]

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[3]California could apply its transfer of assets rule to the SSI categorically needy if it exercised the option, provided by 42 U.S.C. sec. 1396a(f), of utilizing criteria that were in effect on January 1, 1972. California, however, has not adopted this "section 209(b) option."

The transfer rule is applied to the medically needy (J.A. 59) as well as other groups.

California also has promulgated other regulations which set forth financial eligibility rules for medical assistance. California's eligibility regulations permit an individual person who has resources of not more than $1,500 to be eligible for medical assistance benefits under the program for the medically needy (Welf. & Inst. Code sec. 14006; 22 Cal. Admin. Code sec. 50420). Generally excluded from the computation of resources are the individual's home, some income-producing real property and certain other assets. (Welf. & Inst. Code sec. 14006; 22 Cal. Admin. Code secs. 50418, 50425-50489.)[4]

Under the Medicaid program, a state is required to "provide for flexibility in the application of such [eligibility] standards with respect to income by taking into account . . . the costs . . . incurred for medical care or for any other type of remedial care recognized under State law. . . ." (42 U.S.C. sec. 1396a(a)(17).) This procedure, commonly called "spend-down," is implemented in California's Medi-Cal program and referred to as the "share of cost" requirement (22 Cal. Admin. Code sec. 50651 et seq.).

The "share of cost" provisions permit an individual who otherwise meets the resource requirements of the Medi-Cal program to become eligible for Medi-Cal by devoting excess income to the costs of his or her medical care. An individual's "share of cost" is calculated by subtracting the applicable "maintenance need" (as determined by 22 Cal.

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[4]Federal law permits states, under limited circumstances, to recover the cost of medical assistance from the assets (exempt and nonexempt) which are left in the individual's estate after death (42 U.S.C. sec. 1396a(a)(18)). California has not implemented such a recovery procedure. (Cf. *Dawson v. Myers* (9th Cir. 1980) 622 F.2d 1304, 1308; J.A. 60.)

Admin. Code sec. 50601 et seq.) from the net nonexempt income available for a particular month; the remainder is the "share of cost" for that month. (22 Cal. Admin. Code sec. 50653.) The individual becomes eligible for Medi-Cal for that month as soon as health care costs have been obligated or paid in an amount equal to the share of cost. (22 Cal. Admin. Code secs. 50655.)

3. Rossye Dawson, on behalf of herself and others similarly situated, instituted this action on June 19, 1978, by filing a complaint for declaratory and injunctive relief in the district court for the Central District of California. (J.A. 60.) The gravamen of her complaint was that California's transfer of assets rule was inconsistent with applicable portions of the Social Security Act and thus violated the Supremacy Clause. It was also alleged that the rule violated the equal protection and due process clauses of the Fourteenth Amendment. Plaintiff Dawson has since died. (J.A. 60.) Two other individuals, Antonia Beltran and Enosinsio Manahan, intervened seeking the same relief. (J.A. 2.) Both plaintiffs in intervention had transferred all or part of their interest in their homes to relatives. (J.A. 6, 7.) Both plaintiffs were denied Medi-Cal benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. (J.A. 61.) Neither of the plaintiffs was able to overcome the presumption that they had transferred their assets with the intent to qualify for assistance.[5] (J.A. 61.) The district court certified a class

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[5]In October 1978, the county computed Beltran's period of ineligibility to be 885 months. As a practical matter, Beltran would not be ineligible for 885 months because the ineligibility period would be substantially reduced by deducting the amount of medical expenses actually paid from the excess net value of the property transferred. (22 Cal. Admin. Code secs. 50411, 50605.) Beltran applied and was found eligible for Medi-Cal effective from March 1, 1980 (Pet. brief, p. 8 fn. 7).

consisting of all those aged, blind, and disabled individuals who, as of June 19, 1978, have been or are denied Medi-Cal benefits because of California's transfer of assets rule. (J.A. 45.) Plaintiff Manahan died while the case was before the Court of Appeals. (Pet. Brief, p. 11, fn. 11.) On May 10, 1979, the district court granted California's motion for summary judgment and denied plaintiff's cross-motion for summary judgment. (J.A. 54.) The court found that California's transfer of assets rule did not conflict with the Supremacy Clause, nor did it constitute a denial of equal protection or due process. (J.A. 47.)

4. On May 11, 1979, plaintiffs appealed to the Court of Appeals for the Ninth Circuit. In a unanimous decision dated May 14, 1980, a three-judge panel of the Court of Appeals for the Ninth Circuit affirmed the judgment of the lower court. (*Dawson v. Myers* (9th Cir. 1980) 622 F.2d 1304; J.A. 56.)

5. Plaintiffs filed a petition for rehearing and a suggestion for rehearing en banc. The Secretary of HHS also made a motion for permission to file an amicus curiae brief. On July 30, 1980, a three-judge panel voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc. (J.A. 74.) The full court was advised of the suggestion for en banc rehearing and no judge of the court requested a vote on the suggestion. (J.A. 74.) In addition, the motion by the Secretary of HHS for permission to file an amicus curiae brief was denied. (J.A. 74.) The plaintiffs then filed a petition for writ of certiorari. On November 3, 1980, this court granted the petition limited solely to the Supremacy Clause question. (J.A. 75.)

On December 13, 1980, the Boren/Long Amendment No. 1936 to HR 8406 passed both the Senate and House of Representatives. (See 1979-1980 CCH Congressional In-

dex, p. 34,547 (December 19, 1980).) This Amendment permits the use of transfer of assets rules in both the Title XVI SSI/SSP cash assistance program and the Title XIX Medicaid program.[6] On December 28, 1980, that Amendment was signed into law.[7]

Summary of Argument.

A. The Medicaid program (42 U.S.C. sec. 1396 et seq.) is a cooperative federal-state program enacted to provide medical assistance to needy individuals. In order to receive federal financial participation for its Medicaid program, a state must adopt a plan for medical assistance which conforms to federal statutes and regulations. A state is given considerable flexibility, however, in the administration of its medical assistance program, especially when necessary to deal with the serious fiscal problems associated with mounting welfare costs. A corollary of this general proposition is that the federal Supremacy Clause will not be applied to void provisions of these state programs unless there is clear congressional intent to do so.

As part of its Medi-Cal program, California has adopted a transfer of assets rule (Cal. Welf. & Inst. Code sec. 14015; 22 Cal. Admin. Code secs. 50408, 50409). Its purpose is to discourage the intentional divestment of assets in order to establish eligibility for medical assistance. Although in California such a rule cannot be applied to the SSI categorically needy (those aged, blind and disabled individuals

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[6]See fn. 22, *infra*.

[7]See fn. 21, *infra*. By virtue of this Amendment, Congress has substantially remedied the serious fiscal problems alluded to by respondents, *infra*, which would have confronted California and other states. Respondents' brief was substantially completed prior to the enactment of the Boren/Long Amendment. Accordingly, respondents' comments relating to future fiscal impact should be read in light of this Amendment.

who receive SSI cash assistance), there is no prohibition against its application to the optional medically needy group (those aged, blind and disabled individuals who would qualify for SSI cash assistance, except that they have sufficient income and resources to cover their living expenses, aside from medical costs). In the absence of any clear congressional intent to preclude the use of such a rule, and in view of its manifest purpose to preserve the fiscal soundness of the Medi-Cal program in California, the transfer of assets rule may validly be applied to the medically needy.

First, section 1396a(a)(10)(C) of Title 42, United States Code, does not prohibit the application of the transfer of assets rule to the medically needy. That federal statute specifically excludes income and resource criteria from its requirement that the medically needy and categorically needy be treated alike. Since the transfer of assets rule can be properly characterized as a substantive financial eligibility rule which deals with an individual's income and resources, it may be utilized in California's medically needy program.

The transfer of assets rule also does not violate the "comparability" provisions of section 1396a(a)(10)(C). Congressional intent indicates that the requirement of comparability was meant to apply between the various groups of the medically needy—aged, blind and disabled. Its purpose was not to require "comparable" treatment between the categorically needy and medically needy. Even if section 1396a(a)(10)(C) is read to require comparability between the categorically needy and the medically needy, the financial eligibility standards as a whole are similar enough to be considered "comparable."

The informal opinion of the Department of Health and Human Services, as expressed through letters written by regional administrators, that the transfer of assets rule violates section 1396a(a)(10)(C) should be accorded little

weight. HHS has approved California's Medi-Cal plan, and has declined to take any action against that plan. Furthermore, the deference which the courts normally accord an administrative agency's interpretation is not absolute. Where, as in this case, the interpretation is both inconsistent with a statutory mandate, and will frustrate a clearly-expressed congressional policy, the court should not defer to HHS' construction of section 1396a(a)(10)(C).

Second, the transfer of assets rule does not violate section 1396a(a)(17)—the requirement that only "available" income and resources be considered in making eligibility determinations under the Medicaid program. That section was meant to apply to a situation where income and resources were neither presently available, *nor had they ever been available,* to the applicant. It was not intended to apply to a person who divested himself or herself of assets in order to qualify for medical assistance. Furthermore, certain federal regulations explicitly permit states to consider assets and income not presently available in determining eligibility.

Third, section 435.401(c) of Title 42, Code of Federal Regulations, does not prohibit application of the transfer of assets rule to the medically needy. Although that regulation provides that the requirements for determining eligibility for the medically needy cannot be more restrictive than those used for the categorically needy, it clearly was not meant to apply to *financial eligibility* conditions, such as the transfer of assets rule. To interpret that regulation to apply to financial eligibility conditions would result in an inconsistency, since the medically needy are, by definition, subject to different income and resource requirements. Furthermore, the prior wording of section 435.401(c), as well as the context in which section 435.401(c) appears, indicate that

it was meant to refer to the nonfinancial, general eligibility criteria, such as citizenship, alienage or residence.

B. California's transfer of assets rule is also necessary to effectuate the purposes of the Medicaid program. It preserves finite state resources for those who are truly in need of medical assistance. It also prevents the type of fraud and abuse which, if left unchecked, would rapidly deplete the limited funds available for medical assistance. The antifraud provisions of section 1396h(a) of Title 42, United States Code, are of no assistance to states as they do not cover the situation where individuals intentionally divest themelves of assets in order to manufacture eligibility.

The transfer of assets rule is also essential to the proper functioning of the spend-down requirement contained in section 1396a(a)(17) of Title 42, United States Code, and implemented in California as its "share of cost" provisions (22 Cal. Admin. Code sec. 50651 et seq.). The "share of cost" rules require an individual to devote excess income to the cost of medical care. The intentional divestment of assets would render these federally-required provisions ineffective.

C. Recently enacted legislation and accompanying congressional intent are supportive of respondents' position. The Boren/Long Amendment No. 1936 to HR 8406, recently passed by Congress and signed into law on December 28, 1980, is a clear expression of legislative intent that states should be permitted to apply transfer of assets rules for *both the categorically needy and the medically needy*. That legislation was found necessary to correct the frequently utilized practice whereby persons with substantial assets intentionally divest themselves of such assets so that the costs of long-term institutional care will be borne by the state through its medical assistance program. The enactment of the Boren/Long Amendment cannot be interpreted as a

statement of Congress' opinion that, prior thereto, states could not apply transfer of assets rules to the medically needy. Courts have acknowledged that the use of subsequent legislative pronouncements form a hazardous basis for inferring the intent of an earlier Congress. Furthermore, certain reports of the Senate Finance Committee explicitly state that legislation allowing states to apply transfer rules should not be construed as agreement with those decisions which have struck down such rules.

ARGUMENT.

I.

CALIFORNIA'S TRANSFER OF ASSETS RULE DOES NOT VIOLATE THE SUPREMACY CLAUSE AS IT DOES NOT CONFLICT WITH ANY FEDERAL STATUTE OR REGULATION.

Persons who comprise the class which includes the named petitioner have all been found to have transferred their assets for less than adequate consideration *with the intent to qualify for assistance* (Cal. Welf. & Inst. Code sec. 14015). All of them were found to have had sufficient assets that could have been used to support their present medical needs. The purpose in implementing the transfer of assets rule is not so much to penalize these individuals. It is rather to preserve state funds for those persons who are truly in need of government-funded medical care. This Court recognized this aim when it said that restrictions on welfare eligibility attempt ". . . to promote self-reliance and civic responsibility, to assure that limited state welfare funds be spent on behalf of those genuinely incapacitated and most in need, and to cope with the fiscal hardships enveloping many state and local governments. . . ." (*New York Dept. of Social Services v. Dublino* (1973) 413 U.S. 405, 413.) The Medi-Cal system could not long survive the drain on its funds if individuals in the state who transferred assets for inadequate consideration with the intent to qualify for assistance could receive medical benefits. And, certainly, the "self-reliance" and "civic responsibility" about which this Court spoke would not be promoted by such attempts to qualify for assistance at the expense of the public treasury.

These policy considerations would carry little weight in the face of explicit federal statutes or regulations prohibiting the state's imposition of a transfer of assets rule. However, no such statutes or regulations exist. Nowhere in either Title

XIX of the Social Security Act or the regulations promulgated thereunder is there any mention of a prohibition against transfer of assets rules. In fact, the only logical reading of those statutes and regulations is that a state may impose different income and resource eligibility criteria on the optional medically needy group than those imposed on the categorically needy in order to promote the efficient administration of its Medicaid program.

Petitioner argues that California's transfer of assets rule violates the Supremacy Clause in that it conflicts with portions of the Social Security Act and applicable regulations. Specifically, petitioner alleges that the rule conflicts with 42 United States Code sections 1396a(a)(10)(C) and section 435.401 of the Code of Federal Regulations because it imposes an additional requirement on the medically needy which is not imposed on the categorically needy. The Ninth Circuit found no conflict with either of these sections.[8] (*Dawson v. Myers,* 622 F.2d at 1309-1313; J.A. 62-67, 69-70.) Although other cases have reached the contrary conclusion,[9] respondents submit that the court below reached the correct decision based upon the language of those sections and applicable case law.

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[8]The Ninth Circuit also found that the transfer rule did not conflict with 42 U.S.C. sec. 1396a(a)(17)(B). (J.A. 67.) Petitioner has not argued in her brief that the transfer of assets rule violates this section. Because petitioner did raise this argument in her petition for writ of certiorari, respondents will address it in their argument, *infra.*

[9]*Fabula v. Buck* (4th Cir. 1979) 598 F.2d 869, *Scarpuzza v. Blum* (2d Dept. 1980) 426 N.Y.S.2d 505. Both the lower court in *Caldwell v. Blum* (CCH Medicare and Medicaid Guide, para. 30,093 (N.D.N.Y. 1979)) and the Second Circuit, *Caldwell v. Blum* (2d Cir. 1980) 621 F.2d 491, *pet. for cert. pending* No. 79-2034 (filed June 24, 1980), as well as *Robinson v. Pratt* (CCH Medicare and Medicaid Guide, para. 30,605 (D. Mass. 1980)) also found the transfer of assets rule violative of the Supremacy Clause in those states which did not elect the option available in 42 U.S.C. sec. 1396a(f). These latter three decisions were not final rulings on the merits, but were in the context of motions for a preliminary injunction.

Medicaid has been described as an experiment in cooperative federalism with boundless options. (*Michael Reese Physicians and Surgeons, S.C. v. Quern* (7th Cir. 1979) 606 F.2d 732, 735.) States have considerable flexibility in the administration of their individual programs. (*Norman v. St.Clair* (5th Cir. 1980) 610 F.2d 1228, 1230.) This Court has recognized that states face the "critical problem of mounting welfare costs and the increasing financial dependency of many of its citizens." (*New York Dept. of Social Services v. Dublino*, 405 U.S. at 413.) The severity of these problems requires that states be given "considerable latitude in attempting their resolution." (*Ibid.*)

The starting point in any analysis involving the Supremacy Clause is the basic principle that the courts will not assume that a federal statute was intended to supersede the exercise of a valid state power unless clearly and unambiguously stated. In *Dublino, supra*, this Court held:

> "This Court has repeatedly refused to void statutory programs, absent congressional intent to pre-empt them.
>
> " 'If Congress is authorized to act in a field, it should manifest its intention clearly. It will not be presumed that a federal statute was intended to supersede the exercise of the power of the state unless there is a clear manifestation of intention to do so. The exercise of federal supremacy is not lightly to be presumed.' *Schwartz v. Texas*, 344 U.S. 199, 202-203 (1952)." (*Dublino*, 405 U.S. at 413.)

This principle becomes even more applicable under the Medicaid program, as Congress has expressly required state Medicaid programs to adopt certain procedures to curb abuses and has not prevented state welfare departments from instituting other reforms that would fall within their discre-

tion in administering these programs. (*Michael Reese Physicians and Surgeons, S.C. v. Quern*, 606 F.2d at 735.)

Neither the statutes nor the regulation upon which petitioner relies specifically prohibit California's imposition of a transfer of assets rule. Petitioner can point to no provision in the Social Security Act which mandates that a state may use only eligibility requirements explicitly authorized by federal statute. Petitioner can likewise cite no requirement that the eligibility rules for the optional medically needy group must be identical to those applied to the categorically needy.

A. The Transfer of Assets Rule Does Not Conflict With 42 United States Code Section 1396a(a)(10)(C).

Petitioner's primary argument is that California's transfer rule conflicts with 42 United States Code section 1396a(a)(10)(C). Section 1396a(a)(10)(C) provides that, if a state chooses to make medical assistance available to other groups besides the categorically needy (those receiving aid or assistance under certain state welfare plans or supplemental security income benefits under Title XVI) it must provide:

> "(i) for making medical assistance available to all individuals who would, *except for income and resources*, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services. . . ." (Emphasis added.)

The plain meaning of this statute is that a state must make medical assistance available to the medically needy to the same extent as the categorically needy, *except for income*

and resource requirements. The Ninth Circuit held that the transfer of assets rule is a substantive eligibility requirement that directly applies to the state's income and resource eligibility criteria.[10] (*Dawson v. Myers*, 622 F.2d at 1310; J.A. 63-64.) Petitioner misconstrues the law when she argues that federal law requires that no more restrictive eligibility conditions be employed against the medically needy than against the categorically needy. Section 1396(a)(10)(C) excludes income and resource criteria from these requirements. If the same financial eligibility conditions were employed for the two groups, there would be no difference between them. The transfer of assets rule is a financial eligibility condition which directly affects the individual's income and resource levels. Section 1396a(a)(10)(C) specifically permits such differentiation between the two groups of covered individuals.

The second part of section 1396a(a)(10)(C) requires that a state plan must make medical assistance available to individuals ". . . who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services. . . ." Congress has given some guidance on which beneficiaries shall have their eligibility determined by "comparable" standards. The legislative history of Title XIX is clear that by "comparable standards" of income and

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[10]The district court below, as did the district court in Maryland and the Supreme Court in Wisconsin, characterized the transfer rule as a collateral or procedural eligibility requirement which was permissible under the Social Security Act. (*Dawson v. Beach*, No. 78-2350 (C.D. Cal. 1979; J.A. 52; *Fabula v. Solomon* (D. Md. 1978) 463 F.Supp. 830, *rev'd. sub nom. Fabula v. Buck* (4th Cir. 1979) 598 F.2d 869; *Lerner v. Division of Family Services* (Wis. 1975) 70 Wis.2d 670, 235 N.W.2d 478.) Whether the transfer of assets rule is interpreted as a substantive financial eligibility rule or a collateral eligibility requirement, respondents submit that the rule does not conflict with the Supremacy Clause.

resources, Congress intended to require comparability as among the different groups of medically needy, rather than comparability between the categorically needy and the medically needy.

> "Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is *comparable* as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. *Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children* who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal." (Emphasis added.) (Sen.Rep. No. 404, 89th Cong., 1st Sess., (1965), reprinted in [1965] *U.S. Code Cong. & Admin. News,* 1943, 2017.)

Congress, therefore, required that, within the medically needy group, the aged, the blind and the disabled must have their eligibility determined by comparable income and resource limitations. It did not require comparability as between the categorically needy and the medically needy.[11]

Even if the second part of section 1396a(a)(10)(C) is read as requiring comparability between the categorically needy and the medically needy, the Ninth Circuit found:

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[11]Although the Second Circuit in *Caldwell v. Blum* (2d Cir. 1980) 621 F.2d 491, rejected New York's argument that the comparability requirement was only meant to apply between the various groups of medically needy, the court conceded that "the State's argument is not without some force. . . ." (*Caldwell, supra,* at 497.)

> "The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the *medically needy* group (including the transfer rule) are not comparable to those which are used under the SSI program." (*Dawson v. Myers*, 622 F.2d at 1311; J.A. 65.)

For example, Title XVI of the Social Security Act requires that, in determining the resources of an individual, such items as the individual's home, household goods, personal effects, an automobile and other real property essential to the means of self support shall be excluded. (42 U.S.C. sec. 1382b(a).) California has corresponding exclusions in determining eligibility for Medi-Cal: real or personal property used as a home (22 Cal. Admin. Code sec. 50425), household items (22 Cal. Admin. Code sec. 50465), personal effects (22 Cal. Admin. Code sec. 50467), an automobile (22 Cal. Admin. Code sec. 50461), and other real property (22 Cal. Admin. Code sec. 50427). Therefore, as the court below noted, the rules for determining financial eligibility for Medi-Cal are "comparable" to those utilized in the Title XVI SSI program.

Section 1396a(a)(10)(C)(i) specifically permits the states to make medical assistance available to the medically needy, i.e., those "who have insufficient . . . income and resources to meet the costs of necessary medical and remedial care or services . . . ." This provision cannot reasonably be construed to require the state to provide medical assistance to individuals who purposefully divest themselves of their assets so as to qualify for the Medicaid program. On the contrary, the provision would seem to exclude such individuals by imposing on the state the obligation to cover only individuals who lack sufficient income and resources to

meet the cost of medical care, as opposed to individuals who manufacture eligibility by giving their assets to relatives.

Petitioner bases her argument on letters written by regional administrators of HHS stating that state transfer rules are inconsistent with section 1396a(a)(10)(C) because they impose more restrictive requirements on the medically needy than on the categorically needy. An agency's interpretation of the law which it is charged with administering is not, however, entitled to complete deference. In a recent case dealing with HHS' interpretation of certain Medicare regulations, it was held:

> "The deference which a reviewing court is to afford to an agency's interpretation of its regulations is not total, however. Congress has vested in the court a reviewing function over the action of the agency, including its interpretative decisions. 42 U.S.C. section 1395oo(f), 5 U.S.C. sections 701-706. We would be abdicating our judicial responsibility if we were to pass on the propriety of the Secretary's interpretation without subjecting it to some degree of scrutiny. As where courts review an agency's construction of a statute which the agency administers, 'the deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia. . . .' *American Ship Building Co. v. NLRB*, 380 U.S. 300, 318 (1965); *Volkswagenwerk Aktiengesellschaft v. Federal Maritime Commission*, 390 U.S. 261 (1968). Even though the Medicare reimbursement area is complex, and to a great degree left to the Secretary to structure, his interpretations are nonetheless subject to our examination. [Footnotes omitted.]" (*Pacific Coast Medical Enterprises v. Harris* (9th Cir. March 28, 1980) .... F.2d .... , slip op. 2516, 2525-2526.)

Similarly, in the absence of judicial review, this court should not defer to HHS' interpretations that state transfer rules are inconsistent with section 1396a(a)(10)(C). Examination of the pertinent statutes and regulations amply demonstrate that HHS' letter interpretation should not be relied upon as a true indicator of congressional intent in establishing the Medicaid program.

Congressional policy underlying a statute as well as other compelling policy considerations are a more reliable measure of statutory interpretation. Courts have recognized this principle.

> "However, the courts do not merely 'stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute.' *NLRB v. Brown,* 380 U.S. 278, 291, 85 S.Ct. 980, 988, 13 L.Ed.2d 839 (1965), quoted in *Volkswagenwerk v. FMC,* 390 U.S. 261, 272, 88 S.Ct. 929, 935, 19 L.Ed.2d 1090 (1968). Nor will the courts 'defer to an administrative construction where there are compelling indications that it is wrong.' *Marathon Oil Co. v. Kleppe,* 556 F.2d 982, 986 (10th Cir. 1977.)" (*Baker v. United States* (9th Cir. 1980) 613 F.2d 224, 227.)

In the case at bar, Congress has given the states wide latitude in the administration of their Medicaid programs. Further, in 1972, Congress repealed section 1396b(e) of Title 42, a statute which required a state to make efforts in the direction of broadening the scope of care and services and in the direction of liberalizing the eligibility requirements for medical assistance. (Pub.L. 92-603, Title II, section 230, 86 Stat. 1410.) By repealing this statute, Congress recognized its awareness of the fiscal crises confronting states in the administration of their Medicaid programs. The effect

of upholding the interpretation taken by HHS' regional administrators would be to make Medicaid available to any aged, blind or disabled person, regardless of whether that individual had sufficient income and resources for medical needs. Such a result flies directly in the face of the congressional intent toward alleviating the fiscal burdens of state Medicaid programs.

Furthermore, HHS' opinion of the transfer of asset rule is far from consistent. HHS has approved California's state plan in spite of the fact that the transfer rule (Cal. Welf. & Inst. Code sec. 14015) has been in effect since 1965. Its continuing approval of California's state plan and its failure to take any action against the plan supports respondents' argument that the transfer rule and its administrative application in California complies with the relevant statutes and regulations under the Social Security Act. (45 C.F.R. section 201.3(d).) This continuing endorsement has been considered a very persuasive factor in determining whether statutory and regulatory requirements have been violated. (*Michael Reese Physicians and Surgeons, S.C. v. Quern* (7th Cir. 1979) 606 F.2d 732, 735-736.) Faced with a challenge to an Illinois regulation which allegedly violated a federal Medicaid statute, the Court in *Michael Reese, supra,* upheld the regulation:

> "In passing the Medicare and Medicaid Antifraud and Abuse Amendments, Congress required state programs to adopt certain procedures to curb abuses. Congress did not prevent state welfare departments from instituting other reforms which would fall within their discretion in administering the Medicaid programs. Medicaid is an experiment in cooperative federalism, (citations omitted), which literally abounds with options, (citations omitted). Medicaid is designed to be flexible enough to meet the varying needs of each state

> which elects to participate in the program. *By approving the Illinois Medicaid plan, and by declining thus far to take any action against the modification in the plan, the Department of Health, Education and Welfare has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements.*" (Emphasis added.) (606 F.2d at pp. 735-736.)

Likewise, by approving California's Medi-Cal program and declining to take any action against it, HHS has in effect expressed its view that the California transfer of assets rule is in compliance with federal law and regulations. (45 C.F.R. sec. 201.3(d).)

B. The Transfer of Assets Rule Does Not Violate the Federal Requirement That Only Available Income and Resources Be Considered in Determining Eligibility.

California's transfer of assets rule is not violative of 42 United States Code section 1396a(a)(17)(B). That statute provides that only available income and resources may be considered in eligibility determinations under the Medicaid program. The state's prerogative in determining eligibility for medical assistance is cast in unmistakably broad terms under Title XIX of the Social Security Act:

> "A State plan for medical assistance must . . . (17) include reasonable standards for determining eligibility for and the extent of medical assistance under the plan which are consistent with the objectives of this subchapter. . . ." (42 U.S.C. section 1396a(a)(17)(A).)

In another context, this Court has specifically construed this section to confer "broad discretion" on the states. (*Beal v. Doe* (1977) 432 U.S. 438, 444.)

In *Lerner v. Division of Family Services* (Wis. 1975) 235 N.W.2d 478, 70 Wis.2d 670, the Supreme Court of Wis-

consin held that the Wisconsin transfer of assets rule did not violate Title 42, United States Code section 1396a(a)(17)(B). The Wisconsin statute is very similar to California's. It presumes that a transfer of property for inadequate consideration within two years prior to the date of application for medical assistance is made in order to receive benefits. The ineligibility lasts for a period during which the value of the asset would have supported the applicant.

The Wisconsin Supreme Court discussed the cases which have considered the availability rule and found that they fall into two categories. One group of cases concerned state regulations which considered the resources of certain relatives as available to the applicant. The second group of cases specifically dealt with a prior divestment of assets. The distinction between the two lines of cases is critical. In the first group of cases, the resources attributed to the applicant were neither presently available *nor had they ever been available*.[12] In those cases which dealt with a prior transfer of assets, the courts found that the divestment negated any claims based on the unavailability of resources. The facts giving rise to the present unavailability are, therefore, determinative on the issue of what is an available resource. (*Lerner*, 235 N.W.2d at p. 483.)

The Wisconsin court in *Lerner* held that the inadequacy of consideration received for transfers of property could properly be considered in determining fraudulent intent. The

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[12]In her Petition for Writ of Certiorari, petitioner cites several cases falling within this first group. (Pet. for Writ of Cert., pp. 14-15.) These decisions are not relevant in that they concern the "deeming" of resources that were never actually available to the applicant or recipient. They focus on the legal responsibility of spouses, relatives and others to support the applicant or recipient *where there has been no intentional divestment of assets*.

presumption that a prior divestment of property was made for the purpose of establishing eligibility does not operate to deny benefits to persons without available resources.

> "It merely requires the petitioner to demonstrate that the lack of presently available resources is not the result of a divestment of property for the purpose of qualifying for benefits. Thus, the statutory provision is not in conflict with the federal statute and regulations, but is merely a procedure for determining what assets are, in fact, available to meet present needs or, but for divestment, would have been available. Petitioner is not precluded from making a showing that the specific divestment was not made in contemplation of benefits or without receiving full and adequate consideration. Any interpretation which finds conflict between the federal statute and the state provision would seem to allow for extensive abuse of the medical assistance program, since a failure to require the showing mandated by sec. 49.47(4)(d), Stats., could result in any and every person who meets the income eligibility requirements automatically becoming eligible for benefits by the simple expedient of giving away or signing over control of all measurable assets. *Such a result could not have been contemplated by the legislature when it enacted Title XIX*, nor by HEW when it promulgated regulations thereunder." (Emphasis added.) (*Lerner*, 235 N.W.2d at pp. 483-484.)

In *Rinefierd v. Blum* (4th Dept. 1979) 412 N.Y.S.2d 526, the Appellate Division of the Supreme Court in New York held that New York's transfer of assets rule did not violate the availability provision in Title 42, United States Code section 1396a(a)(17)(B). The New York court acknowledged that a state transfer of assets rule which assumes assets are available to recipients when, in fact, such assets are not available would violate the Supremacy Clause. But

those cases which so held were dealing with statutes which disqualified an applicant *solely because of a transfer*. New York's statute (like California's) denies assistance only where the transfer is made for the purpose of qualifying for medical assistance. (*Rinefierd*, 412 N.Y.S.2d at 529.)

Following the reasoning in *Rinefierd, supra*, the California transfer of assets rule is designed to prevent transfers of funds or property which are "sham or spurious" or made with the intent to qualify for assistance. California's rule, therefore, serves a legitimate interest in assuring that limited state medical assistance funds "be spent on behalf of those genuinely incapacitated and most in need. . . ." (*Rinefierd*, 412 N.Y.S.2d at 529, quoting *Dublino, supra*.)

Finally, there is nothing in the plain language of section 1396a(a)(17)(B) or in the legislative history of that statute which necessarily equates the term "available" with *present* record title or ownership. (*Dawson v. Myers*, 622 F.2d at 1312; J.A. 68.) Congress intended that this sattute correct the situation where, for example, contributions from relatives or support payments from absent fathers, which are not actually received by the needy individual, are included as part of that individual's available income. (Sen.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] *U.S. Code Cong. & Admin. News*, 1943, 2018.) Further support for this interpretation lies in the federal regulations, which authorize a state to consider an applicant's income and assets six months in the future in determining eligibility. (42 C.F.R. sections 435.831(a), 435.845(b).) "Since a state is authorized to consider future assets it must follow that it should also be allowed to consider those assets which have been recently disposed of under circumstances which indicate that the purpose was to qualify for public medical assistance." (*Dawson v. Myers*, 622 F.2d at 1313; J.A. 68.)

Case law and the plain language of 42 U.S.C. section 1396a(a)(17)(B), therefore, establish that a statute such as California's does not violate the federal requirement that only available resources shall be considered.[13] Without a transfer of assets rule *any* persons could qualify for medical assistance by merely divesting themselves of sufficient assets. This would quickly bankrupt a state's medical assistance program and would result in the denial of all benefits to those truly in need. This could not have been the intent of the federal government when it enacted the Medicaid program.

C. The Transfer of Assets Rule Does Not Conflict With Section 435.401(c) of Title 42 of the Code of Federal Regulations.

The petitioner also contends that the transfer rule conflicts with 42 Code of Federal Regulations section 435.401(c). Basically, this regulation provides that a state cannot use requirements for determining eligibility for the medically needy which are more restrictive than those used for the categorically needy. The Ninth Circuit found that this regulation does not apply to financial eligibility requirements such as the transfer rule. (*Dawson v. Myers*, 622 F.2d at 1313; J.A. 69.)

Different financial requirements apply to the medically needy than apply to the categorically needy. By definition the two groups are distinguishable—the categorically needy

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[13]Neither *Scarpuzza v. Blum* (2d Dept. 1980) 426 N.Y.S.2d 505, the district court in *Caldwell v. Blum* (CCH Medicare and Medicaid Guide, para. 30,093 (N.D.N.Y. 1979)), nor *Fabula v. Buck* (4th Cir. 1979) 598 F.2d 869 discussed the "availability" requirement of 42 U.S.C. sec. 1396a(a)(17). In the Second Circuit decision in *Caldwell v. Blum* (2d Cir. 1980) 621 F.2d 491, 496, the court merely mentioned that plaintiff's position was "buttressed" by 42 U.S.C. sec. 1396a(a)(17), without actually analyzing that statute.

have *less* income and resources than the medically needy. Therefore, section 435.401(c) cannot be read to apply to financial eligibility conditions such as the transfer rule because such an interpretation necessitates reading an inconsistency into the federal Medicaid statutes and regulations.

There is additional support for the conclusion that section 435.401 does not apply to *financial eligibility* requirements. First, section 435.401 is found under the general heading entitled "*Subpart E—General Eligibility Requirements.*" (Part 435 of Title 42, C.F.R.) Other subparts state specific and detailed guidelines for financial eligibility requirements. Subpart G sets forth the "*General Financial Eligibility Requirements.*" Subpart H sets forth the "*Financial Requirements for the Categorically Needy.*" Subpart I sets forth the "*Financial Requirements for the Medically Needy.*" None of these specific subparts state that a state Medicaid agency cannot impose a transfer of assets rule on the medically needy. Proper statutory interpretation mandates that these specific and detailed guidelines for financial eligibility requirements control over the general rule stated in section 435.401. Second, there is no discussion of financial eligibility conditions in any other sections of Subpart E. Instead, as the Ninth Circuit noted, the sections of Subpart E concern general eligibility requirements such as citizenship, alienage or state residence. (*Dawson v. Myers*, 622 F.2d at 1313; J.A. 70.) Therefore, the language of section 435.401(c) that eligibility requirements for the medically needy cannot be more restrictive than those for the categorically needy can only refer to those eligibility requirements which are not related to income and resources.

Further support for this interpretation is found in the previous wording of section 435.401(c). When it was designated 45 C.F.R. section 248.2(b)(2), it provided:

"... *Except for financial eligibility*, the conditions of eligibility that are imposed on elective groups [*i.e.*, the medically needy].

"(1) ...

"(2) In the case of aged, blind, or disabled individuals, are not more stringent or more numerous than those imposed on such individuals receiving [SSI] benefits under title XVI. ..." (Emphasis added.) (39 Fed. Reg. 9515 (1974).)

In 1977, that section was renumbered as 42 C.F.R. section 448.2(b)(2). (42 Fed. Reg. 52827 (1977).) When it was renumbered in 1978 as section 435.401(c) and reworded in its present form, HHS noted that there were no substantive policy changes. (43 Fed. Reg. 45176 (1978).) As originally worded, it clearly excepted *financial eligibility* from its requirement that the conditions of eligibility for the medically needy be no more stringent or numerous than those for the categorically needy. The states could, therefore, impose *more stringent financial eligibility conditions* on the medically needy. (*Fabula v. Solomon* (D.Md. 1978) 463 F.Supp. 830, 836; *rev'd. sub nom. Fabula v. Buck* (4th Cir. 1979) 598 F.2d 869.) One would have to conclude that, since the rewording and recodification effected "no substantive changes" (43 Fed. Reg. 45176 (1978)), states would have that same ability under section 435.401(c).

The conclusion that section 435.401 does not apply to financial eligibility requirements is also supported by the fact that sections of Subpart E parallel the subsections of 42 United States Code section 1396a(b). The Ninth Circuit noted, after undertaking a thorough reading of the pertinent statute and regulation, that "... it is apparent that Subpart E (including section 435.401) was designed to carry out the statutory mandate of 42 U.S.C. section 1396a(b) which does not involve financial eligibility requirements." (*Dawson v.*

Myers, 622 F.2d at 1313; J.A. 70.) Regulations are to be construed in light of the statutory mandate under which they issue. (*Pacific Coast, supra*, at 2526.) Applying this principle to the instant case, it is apparent that the Ninth Circuit correctly decided that section 435.401(c) does not apply to financial eligibility requirements such as the transfer of assets rule.

II.

CALIFORNIA'S TRANSFER OF ASSETS RULE IS NOT ONLY PERMITTED UNDER TITLE XIX BUT IS NECESSARY TO EFFECTUATE THE PURPOSES OF THE MEDICAID PROGRAM.

A. The Transfer of Assets Rule Protects the Public Treasury, Discourages Intentional Impoverishment and Ensures That Benefits Are Paid to Those Individuals Truly in Need.

In 1965 the Medicaid program was established in order to assist needy people in meeting the costs of health care. (Social Security Act of July 30, 1965, Pub.L. No. 89-97, 79 Stats. 286, 343.) In 1972, Congress enacted amendments to the Act which reflected congressional concerns for state fiscal interests. (Pub.L. 96-603, Title II, Sec. 230, 86 Stats. 1329, 1410.)

The prevention of fraud is obviously consistent with the intent of the Social Security Act. "Certainly, a State has a valid interest in preventing fraud by an applicant for medical care. . . ." (*Memorial Hospital v. Maricopa County* (1974) 415 U.S. 250, 268; *Buckner v. Maher* (D. Conn. 1976) 424 F.Supp. 366, 373, *aff'd* (1977) 434 U.S. 898.) The Court of Appeals in *Rush v. Smith* (2d Cir. 1978) 573 F.2d 110 has addressed itself to arguments similar to these made by petitioner here. The plaintiffs in that case attacked the New York practice of terminating a recipient's assistance

grant if he or she refused to cooperate in the state's investigation of fraud. The lower court in *Rush v. Smith* (S.D. N.Y. 1977) 437 F.Supp. 576 held that the only allowable eligibility requirements which could be imposed upon applicants for assistance were those specifically authorized by Congress. The Court of Appeals reversed stating that ". . . courts may not void state action under the AFDC program 'so long as the state's actions are not in violation of any specific provision of the Constitution or the Social Security Act.' " (*Rush,* 573 F.2d at 115.) The court found no conflict between the termination of a recipient for the failure to aid in fraud investigations and the federal statutes or regulations. It noted that "Congress has simply not thought it necessary to say anything so patent as that persons who have engaged in fraud or refused to comply with reasonable requests to assist in its investigation may be removed from the rolls." (*Ibid.*) "We find nothing in the Social Security Act that forbids a state to terminate benefits to a recipient who engages in conduct . . . which, if done on a considerable scale, would render continued conduct of the AFDC program impossible. . . ." (*Rush,* 573 F.2d at 117.)

Generally, a state is entitled to adopt reasonable regulations in an effort to prevent fraud. (*Lavine v. Milne* (1976) 424 U.S. 577, 584-585; *Buckner v. Maher* (D. Conn. 1976) 424 F.Supp. 366, 373, *aff'd* (1977) 434 U.S. 898.) This Court should not invalidate California's restriction on fraudulent transfers of assets in the absence of clear legislative intent that such requirements may not be imposed. (*Dublino,* 413 U.S. at 413.)

In *Rinefierd v. Blum* (4th Dept. 1979) 412 N.Y.S.2d 526, the court found that New York's transfer of assets rule, which is similar to California's, is designed to prevent a species of fraud or misrepresentation at the taxpayer's expense. The court stated that the rule:

"... plainly is designed to prevent those transfers of funds or property which may be characterized as sham or spurious or made with fraudulent intent in order for an applicant to claim eligibility. Thus, we consider a transfer of property made in order to qualify an applicant for medical assistance to be a species of fraud. Implicit here in the later-filed application for benefits is the misrepresentation as to the applicant's finances contained in the statement that there exists no available resources. Since immediately prior to the time of transfer assets were available, the fact of transfer coupled with an intent later to file for benefits constitutes a species of misrepresentation or fraud undertaken for the applicant's benefit at the expense of the public fisc.

. . .

"There is little doubt that New York State has a legitimate interest in policing this kind of practice. A state statute that denies benefits to applicants who have utilized what fairly may be termed fraudulent measures to qualify for assistance is not unconstitutional." (*Rinefierd*, 412 N.Y.S.2d at 529)

This type of fraud-preventive statute currently before this court has been known to the law at least since the enactment of 13 Eliz. C. 5 in 1570. The Uniform Fraudulent Conveyance Act, for instance, specifically deals with conveyances for inadequate consideration made by a person about to incur debts.[14] Similarly, the Bankruptcy Act provides that any transfer by a debtor made prior to his bankruptcy with actual intent to hinder, delay, or defraud a creditor may be set aside by the trustee. (11 U.S.C. sec. 548(a).) In enacting

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[14]Section 6 of the Uniform Fraudulent Conveyance Act provides:

"Every conveyance made and every obligation incurred without fair consideration when the person making the conveyance or entering into the obligation intends or believes that he will incur debts beyond his ability to pay as they mature, is fraudulent as to both present and future creditors."

the restriction on transfers of assets for inadequate consideration, the California Legislature merely engrafted the well-recognized prohibition against fraudulent property transfers known to the law for at least 400 years.

The district court below and the district court in Maryland (*Fabula v. Solomon* (D. Md. 1978) 463 F.Supp. 830) considered and rejected the argument that state restrictions on fraudulent transfers of assets for the purpose of qualifying for Medicaid conflict with 42 United States Code section 1396a(a)(10)(C)(i) and its implementing regulations. In the state courts, the *Rinefierd* court, as well as the Wisconsin Supreme Court in *Lerner v. Division of Family Services* (1975) 235 N.W.2d 478, are in accord. Unlike the Ninth Circuit, these courts generally found that a transfer of assets restriction is not a substantive eligibility condition, but is merely in the nature of a collateral or procedural eligibility requirement which is clearly permissible under the Social Security Act. (*Dawson v. Myers,* 622 F.2d at 1310; J.A. 63.)

In *Lerner v. Division of Family Services,* 235 N.W.2d at 484, it was argued that since the eligibility for the SSI cash assistance program is not affected by a transfer of assets, 42 United States Code section 1396a(a)(10)(C)(i) prohibited the state from imposing such a restriction on the medically needy. The Wisconsin Supreme Court disagreed:

> "We do not consider that a conflict exists between the state and federal statute and regulation since there is no indication of legislative intent in Title XIX that a state should not be allowed to protect its citizens against misuse of public funds by the expedient of inquiring into the nature of conveyances which might have taken place for the purpose of obtaining benefits." (*Lerner, supra,* at 485.)

California's statute reflects the state's vital interest in deterring intentional impoverishment and in reserving the state's limited resources for those who are truly in need. Elderly individuals who enter nursing homes may remain there for an indefinite period or in some instances permanently. In New York, the cost of a single month of nursing care was as much as $2,000. (*Rinefierd v. Blum*, 412 N.Y.S.2d at 528.) It was noted by the Senate Finance Committee that "[t]he aged, blind and disabled account for some 64 percent of all program expenditures. They are most likely to need hospital, skilled nursing, and intermediate care facility services which comprise two-thirds of Medicaid benefit costs." (Sen.Rep. No. 95-1111, 95th Cong. 2d Sess. (1978) 24-25, reprinted in CCH Medicare and Medicaid Guide, para. 29,592.)[15]

The minimal cash benefits dispersed under the SSI program provide small incentive for an individual to transfer substantial assets. Effective July 1980, an individual recipient currently receives only $238 per month (Social Security Administration Claims Manual § 12999).[16] This amount is reduced by the recipient's nonexcludable income. (20 C.F.R. § 416.410.) In contrast, there is a significant incentive for a person requring costly long-term medical care to divest himself or herself of assets in order to qualify for Medicaid assistance which would then pay the bills for that care.

Congress itself, on more than one occasion, has recognized the need for restrictions on the intentional divestment of assets in order to establish Medicaid eligibility:

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[15]In New York, it was estimated that the invalidation of the transfer of assets rule would cause the state to expend an additional $150 million per year in Medicaid benefits. (*Blum v. Caldwell*, ... U.S. .... , 100 S.Ct. 1635, 1638 (1980).)

[16]Effective July 1980, California provided supplemental assistance to an individual receiving SSI benefits in the monthly amount of $182. (Social Security Administration Claims Manual § R12999(2)(h).)

> "Where an individual with significant assets is faced with the prospect of substantial medical expenses—particularly in cases where a prolonged period of institutionalization may be needed—present law may provide a strong incentive for him to give those assets away to a friend or relative so as to qualify for medicaid immediately. To the extent that this happens, the costs of the program are increased since medical expenses which could be met from the individual's assets are instead being paid for by public funds." ((1979) Sen.Rep. No. 471, 96th Cong., 1st Sess. 48-49.)

If the transfer rule is found unconstitutional, it will be invalid for everyone, not merely for the named petitioners.[17] In-

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[17]Petitioner, citing a few examples, some of which occurred outside California and are, therefore, not before this Court, argues that the transfer rules unjustly deprive individuals of coverage. In effect, she is urging the court to strike down the statute as unconstitutional on the basis of its application in a few isolated instances. Petitioner has failed to introduce any admissible evidence that the rule is applied in California in an unconscionable or unfair manner.

Likewise petitioner states, without any supporting authority, that most people do not divest themselves of assets for the purpose of qualifying for Medi-Cal. The Senate Finance Committee, however, in its explanation of an amendment to one of the reconciliation bills (S2885, § 511) specifically opined that the situation in which a transfer of assets for inadequate consideration is made in "good faith" without an intent to qualify for assistance would be "quite rare." (126 Cong. Rec. § 8250 (daily ed. June 26, 1980).)

Further, petitioner characterizes the application of the transfer rule in California as "heavy-handed" because of the nature of the presumption. Respondents would simply point out that this due process issue is not before the Court. In addition, several courts have upheld transfer of assets rules on due process grounds. (See *Lerner v. Division of Family Services* (1975) 70 Wis.2d 670, 235 N.W.2d 478; *Rinefierd v. Blum* (1979) 412 N.Y.S.2d 526; *Dawson v. Myers* (1980) 622 F.2d 1304; J.A. 70-71.) Those courts which have struck down transfer of assets rules on due process grounds (*Owens v. Roberts* (M.D. Fla. 1974) 377 F.Supp. 45; *Buckner v. Maher* (D. Conn. 1976) 424 F.Supp. 366, *aff'd* (1977) 434 U.S. 898; *Udina v. Walsh* (E.D. Mo. 1977 440 F.Supp. 1151) did so either because the rule provided that any transfer (with or without consideration and for whatever purpose) gave rise to the presumption (*Owens, supra*) or because the presumption utilized

dividuals with substantial assets will benefit from the invalidation of the transfer rule. "This situation damages program credibility by allowing relatively well off individuals to become eligible for medicaid. . . . [and] increases program costs, especially for expenditures for institutional care." (Sen.Rep. No. 95-1111, 95th Cong. 2d Sess. (1978), 24.) Under these circumstances, it is neither unreasonable nor unjust to expect an individual with sufficient resources and income to contribute his or her assets toward the cost of medical assistance. Under the rule, benefits are "provided to those individuals who, in fact, have a financial need, and benefits are denied to the individuals who have artificially created a need by disposing of assets for less than fair consideration." (*Dawson v. Myers*, 622 F.2d, at 1315; J.A. 72.) Therefore, the transfer rule is necessary to protect a state's vital interest in protecting its finite public treasury and providing benefits to those who are truly in need.[18]

Finally, petitioner argues that the transfer rule is unnecessary because of 42 United States Code section 1396h(a). Basically, this statute provides that Medicaid coverage may be denied to an individual who ". . . knowingly and will-

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was an *irrebuttable* one. The presumption used in California's transfer of assets rule is easily distinguishable from those invalidated in *Owens*, *Buckner*, or *Udina*.

It is interesting to note also that petitioner herself never bothered to request an administrative hearing for the purpose of producing evidence to overcome the presumption, pursuant to 22 Cal. Admin. Code § 50409 (J.A. 49) and can hardly complain that the transfer rule, as applied to her, was "heavy-handed."

[18]Furthermore, it should be noted that when an individual is in fact discontinued from Medi-Cal because of the transfer of assets rule, such individual may still receive medical assistance. The counties are required to provide care for indigent residents and those incapacitated by age, disease or accident who are not supported by their relatives or friends, by their own means, or by state or private institutions. (Welf. & Inst. Code § 17000.)

fully makes or causes to be made any false statement or representation of a material fact . . .'' in applying for medical assistance benefits. Section 1396h(a), however, is directed primarily to the offense of fraudulent misrepresentation. It does not impose any penalty against the individual who intentionally gives away assets in order to qualify for Medi-Cal so long as the applicant discloses that a transfer of assets occurred. Therefore, if the individual disclosed the transfer, his or her conduct would not be covered by the prohibition contained in section 1396h(a). Clearly that section alone, without the transfer of assets rule, would not protect the fiscal integrity of a state's Medicaid program and reserve the state's limited financial resources for those in need of medical assistance.

B. The Transfer of Assets Rule Is Necessary for the Implementation of the ''Spend-Down'' Requirement Under Title XIX.

Not only is California's restriction on transfers of assets authorized under 42 United States Code section 1396a(a)(10)(C)(i), but the restriction is manifestly necessary to implement other important provisions of Title XIX.

The Medicaid statute, unlike the SSI statute, affirmatively requires the applicant or recipient to devote excess income and resources to the cost of medical care. This requirement is implemented through what is referred to as the ''spend-down'' procedure. The ''spend-down'' procedure is set forth in 42 United States Code section 1396a(a)(17):[19]

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[19]Under the California Medi-Cal program, ''spend-down'' of income referred to under 42 United States Code section 1396a(a)(17) is called ''share of costs'' and is embodied in Title 22 of the California Administrative Code sections 50651 through 50660. See an explanation of this procedure under ''Statement of the Case,'' *supra*.

> "A State plan for medical assistance must . . . (17) . . . include reasonable standards . . . for determining eligibility . . . and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or any other type of remedial care recognized under State law. . . ."

Thus, in order to become eligible for Medicaid, persons with an income above the allowed income ceiling must go through what is called the spend-down process, i.e., they must incur or pay for their own medical expenses in an amount equal to the amount by which their income exceeds the appropriate income standard for Medicaid. Medical expenses up to the amount of the spend-down liability remain the responsibility of the applicant; Medicaid then pays for (covered) medical care beyond that amount. (See 42 C.F.R. sec. 435.831.)

California's restriction on transfers of assets is crucial to the equitable implementation of the aforementioned spend-down procedure. If applicants are permitted to transfer their resources in order to avoid contributing the income produced by those resources to the costs of medical care, the result will be that the spend-down requirement will be rendered meaningless. If a state could not impose restrictions on transfers of assets, a recipient could simply transfer income-producing resources to one's heirs and avoid the spend-down requirement of contributing to the cost of one's own care. It is plain that the state restriction on intentional divestment of assets is indispensable to the fair implementation of the spend-down procedure.

The situation of Rossye Dawson, the original plaintiff in this case, presents a classic example of how a transfer of

income-producing assets for inadequate consideration frustrates the spend-down (share of cost) provisions. Rossye Dawson had been living in a convalescent hospital at the time she quitclaimed her interest in her home to her daughter and son-in-law, who sold the property a few months later and distributed the proceeds to their three children, Rossye Dawson's grandchildren. The net market value of the property at that time was $20,000. (R.Tab 5, Exhibit A.)

The regulations provide that real property formerly used as a home shall be considered "other real property" effective the first of the month following the date the property is no longer used as a home. (22 Cal. Admin. Code sec. 50425(f).) "Other real property" not exempt as a home may still be exempt if certain conditions are met. (22 Cal. Admin. Code sec. 50427.) Primarily, the property must have a net market value of $25,000 or less; any net market value in excess of this amount is included in the property reserve. (22 Cal. Admin. Code sec. 50427.) The owner must also realize a net yearly income from the property equal to at least six percent of its market value. (22 Cal. Admin. Code sec. 50416.) If Rossye Dawson had retained that real property and rented it, the income received by her would have increased that portion of the cost of her medical care for which she was responsible, i.e., her share of cost. At the time of the transfer, her expenses at the convalescent hospital were approximately $973 per month. (R. Tab 5, Exhibit A.) The income received by the rental of that property could have substantially reduced the liability of the Medi-Cal program for her institutional care.

The spend-down procedure provided for under Title XIX is not found in the SSI statute. (See 42 U.S.C. sec. 1381 et seq.) Moreover, as previously noted, there is little incentive for a person owning substantial assets to convey

those assets to relatives simply to gain the modest monthly income provided under SSI. In contrast, there is significant incentive for a person to divest himself or herself of assets in order to have the state pay for an indefinite period of expensive nursing home care.

III.

THE ENACTMENT OF THE BOREN/LONG AMENDMENT REFLECTS CONGRESSIONAL INTENT THAT TRANSFER OF ASSETS RULES ARE ESSENTIAL.

Petitioner has attempted to make a twofold argument based on subsequent congressional bills which would have explicitly authorized states to impose restrictions on the transfer of assets in their Medicaid programs. On the one hand, petitioner contends that the failure of any of these bills to pass Congress is indicative of legislative intent that the categorically needy and medically needed should be treated identically. Implicit in this contention is petitioner's belief that Congress recognizes the unfairness of imposing transfer of assets rules on recipients of public assistance. On the other hand, petitioner argues that the fact that Congress considered enacting such measures is supportive of her position that states, which do not elect the option in 42 U.S.C. sec. 1396a(f),[20] cannot at the present time impose such rules on the medically needy. Based on the recent

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[20]See fn. 3, *supra*.

passage of the Boren/Long Amendment,[21] petitioner's position is untenable.[22]

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[21]The Boren/Long Amendment No. 1936 passed both the Senate and House of Representatives on December 13, 1980, as part of HR 8406. (See 1979-1980 CCH Congressional Index, p. 34,547 (December 19, 1980).) Counsel for respondents were informed in a telephone conversation with a professional staff member of the Senate Committee on Finance that HR 8406 was signed into law by the President on December 28, 1980. Said staff member also informed counsel for respondents that the slip law, which will be designated Public Law 96-611, has yet to be officially published.

[22]The Boren/Long Amendment No. 1936 to HR 8406, as it appears in the *Congressional Record* at 126 *Cong.Rec.* S16505 (daily ed. December 13, 1980), states:

> "Sec. (a) Section 1613 of the Social Security Act is amended by adding at the end thereof the following new subsection:
>
> " 'Disposal of Resources for Less Than Fair Market Value
>
> " '(c)(1) In determining the resources of an individual (and his eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a)) any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.
>
> " '(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.
>
> " '(3) For purposes of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any.'
>
> " '(b) Section 1902 of the Social Security Act is amended by adding at the end thereof the following new subsection:
>
> " '(j)(1) Notwithstanding any other provisions of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act.

The Boren/Long Amendment would permit transfer of assets rules in both the Title XVI SSI/SSP cash assistance program and the Title XIX Medicaid program. Accordingly, the categorically needy as well as the medically needy would be subject to those rules. The Amendment explicitly permits states to take into consideration the resources of an individual within the preceding two years if the individual gave away or sold assets for less than valuable consideration for the purpose of establishing eligibility for Medicaid. States could presume that the transfer was made for the purpose of becoming eligible for benefits, unless the applicant could rebut the presumption by furnishing convincing contrary evidence. The bill also establishes periods of time during which the states may deny the applicant's eligibility.

In arguing for the passage of his coauthored Amendment, Senator Russell Long characterized a transfer of assets for

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" '(2) If any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

" '(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c).'

"(c) The amendment made by subsection (a) shall be effective with respect to applications for benefits under title XVI of the Social Security Act filed on or after the first day of the first month which begins at least 60 days after the date of enactment of this Act."

the purpose of establishing eligibility for public assistance as:

> ". . . an abusive practice in which certain individuals transfer substantial assets to their families or to others in order to bring themselves down to the welfare eligibility level which will qualify them for payments under the supplemental security income (SSI) program and for fully paid medical care under the medicaid program." 126 *Cong.Rec.* S16505 (daily ed. December 13, 1980).

Senator Long recognized this "abusive practice" as a "substantial fiscal concern for many States." (*Ibid.*)

In support of the Amendment, Senator Long commented upon the unsuccessful attempt to remedy this "subterfuge" earlier in 1980 as part of the budget reconciliation bill (Senate Bill 2885, sec. 511). (*Ibid.*) Although that earlier legislation had passed the Senate, and had been concurred in by the House, agreement could not be reached in the context of the reconciliation conference. (*Ibid.*)

Further support for congressional recognition of the need to allow states to impose restrictions on the transfer of assets for the purpose of establishing eligibility for public assistance can be found in the legislative history of that reconciliation bill referred to by Senator Long (Senate Bill 2885). In the General Discussion of (the Senate) Finance Committee Amendments to Senate Bill 2885 (126 *Cong.Rec.* S8248 (daily ed. June 26, 1980)) the following comments on the practice of transferring assets to establish SSI eligibility were made:

> "The committee believes that it is inappropriate for the public assistance programs to be burdened with the assumption of the support and medical care of individuals who have ample personal resources. For this reason, the committee amendment would require that

> any resources which an individual has given away or sold for less than fair market value would still be considered as available for his support, during the 2 years following the transfer of the asset. The amount considered to be available for support would be the value of the transferred asset less any compensation received for it. The Committee recognizes that there may be cases in which such a transaction takes place in good faith and unforeseen circumstances subsequently require an individual to apply for assistance. *The committee believes that such a situation would be quite rare;* however, the provision would allow the rebuttal of the presumption that a transfer of assets was made in order to qualify for benefits or assistance. The burden of proof in such cases would be on the individual and would require a clear showing that at the time the transfer took place there could not have been reasonable expectation that SSI or medicaid benefits would be needed.'' (Emphasis added.) (126 *Cong.Rec.* S8250 (daily ed. June 26, 1980))

The Senate Finance Committee's explanation of that portion of the reconciliation bill is clearly indicative of Congress' belief that restrictions on the transfer of assets for the purpose of establishing public assistance eligibility are needed as part of both the SSI program and the Medicaid program.

Petitioner would probably argue that the passage of the Boren/Long Amendment merely supports her position that, prior thereto, states which did not choose the section 1396a(f) option were not permitted to apply transfer of assets rules to the medically needy because of the language of section 1396a(a)(10)(C). This use of subsequent legislative history to interpret that statute is, however, of dubious value. The court below correctly recognized that pronouncements by a subsequent Congress are not entitled to the same weight as those of the Congress which enacted a measure. (*Banco*

Nacional de Cuba v. Farr (2d Cir. 1967) 383 F.2d 166, 175, *cert. den.* (1968) 390 U.S. 956.) In *United States v. Price* (1960) 361 U.S. 304, 313, this court stated that ". . . views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." Courts are not bound by such pronouncements and some courts have stated that subsequently expressed congressional views should not be relied upon. (*Dawson v. Myers,* 622 F.2d at 1312; J.A. 66, citing *Mathews v. Weber* (1976) 423 U.S. 261, 272 fn. 7.) Inasmuch as the transfer rule does not conflict with section 1396a(a)(10)(C) and Congress was apparently relying upon HHS' erroneous administrative interpretation of section 1396a(a)(10)(C) (*Dawson v. Myers,* 622 F.2d at 1312; J.A. 66-67), this court should not accord deference to the subsequent legislative history of the Medicaid program.

Furthermore, in this particular context, the Senate Finance Committee, in its explanation of the S2885 reconciliation provisions, specifically pointed out that its attempt to limit the disposal of assets for the purpose of establishing SSI eligibility should not be interpreted as agreement with the reasoning of the cases cited by petitioner in her brief.

> "The committee has been told that transfers of this type frequently occur, particularly in cases where an aged individual may face substantial medical expenses. For example, in connection with protracted nursing home care, by transferring assets to a relative, the individual qualifies not only for SSI but also for medicaid. Moreover, under certain court decisions, the absence of an SSI provision in this area has been found to lead to similar problems in connection with the medically needy segment of the medicaid program. (*The committee does not intend that its recognition of the existence of these court decisions should be con-*

strued as agreement that they are correct.)'' (Emphasis added.) (126 *Cong.Rec.* S8250 (daily ed. June 26, 1980))

Therefore, the enactment of the Boren/Long Amendment and accompanying legislative intent should not be interpreted as a statement of congressional opinion that states could not, under the law prior to that Amendment, apply transfer of assets rules to the medically needy.

Conclusion.

Based on the foregoing, the decision of the Court of Appeals should be affirmed.

Respectfully submitted,

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1981

No. 80-5303

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Petitioner,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH; AND ELISABETH LYMAN, INDIVIDUALLY AND AS DEPUTY DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF OF PETITIONER

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-5303

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Petitioner,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH; AND ELISABETH LYMAN, INDIVIDUALLY AND AS DEPUTY DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF OF PETITIONER

I.

CALIFORNIA'S INTERPRETATION OF 42 U.S.C. §1396a (a) (10) (C) (i) IS INTERNALLY CONTRADICTORY AND LEGALLY UNSUPPORTABLE

The issue of this case is whether California can apply a transfer of assets rule to medically needy applicants when it is forbidden to apply, and does not apply, a transfer rule to the identically situated aged, blind, and disabled categorically needy. Plaintiff contends that the "comparability" requirements of the Medicaid statute forbid this different treatment.

Defendants dispute this analysis, but their arguments demonstrate a serious inconsistency as to whether the statute requires comparability between the categorically and medically needy. Their Summary of Argument states: "[42 U.S.C. §1396a (a) (10) (C)] specifically excludes income and resource criteria from its *requirement that the medically needy and categorically needy be treated alike.*" Brief of Respondents, at 8 (emphasis supplied). One paragraph later, they state that that section's "purpose was not to require 'comparable' treatment between the categorically needy and medically needy." *Id.*, at 8. Their entire analysis is flawed by this inconsistent reading of the statute.

This discrepancy undercuts their conclusory observation as to the "plain meaning of this statute". *Id.*, at 15. The phrase "except for income and resources" does not set limits on financial eligibility conditions for the medically needy; rather, it *defines* the medically needy. They are those individuals who *would* be eligible for cash assistance (i.e., SSI or AFDC) except for the fact that their gross incomes and resources are over the cash assistance levels. Indeed,

defendants themselves recognize that this section provides the definition of the medically needy: "primarily those individuals who would qualify for Title IV-A [AFDC] or Title XVI [SSI] financial assistance except that they have sufficient income and resources to cover their needs, apart from medical expenses." *Id.*, at 2. See also 42 C.F.R. §435.4; Cal. Welf. & Inst. C. §14051 (federal and state definitions of "medically needy").

California can only support its reading of the statute by stating that "[i]f the same financial eligibility conditions were employed for the two groups, there would be no difference between them." *Id.*, at 16. That contention is misleading and incorrect. 42 U.S.C. §1396a(a)(10)(C)(i) establishes the difference: the medically needy have more gross income or resources. That is the only difference, as the medically needy are required to meet the categorical requirements. There is nothing in this first clause of 42 U.S.C. §1396a (a) (10) (C) (i) which indicates that different eligibility conditions — whether of a financial or other nature — must be applied to them. Indeed, if it did, the states would not be limited only to applying transfer rules to the medically needy; they could also apply other more restrictive eligibility conditions, such as lower income levels. This would lead to the inconsistent result of the medically needy having their income after medical expenses reduced to a level below that of the categorically needy, a result which directly counters the very premise of the medically needy program. See, *e.g.*, S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2019 (cited in Brief for Petitioner, at 18; see also *id.*, at 26-27).

Having determined, however, that the first part of 42 U.S.C. §1396a (a) (10) (C) (i) provides a financial eligibility exception to the general rule of comparability

between the categorically and medically needy, the state then inconsistently urges that the second part of the provision does not require any comparability between those two groups.[1] Plaintiff does not dispute the state's claim that the "comparability" provision in the second clause requires equal treatment between different groups of the medically needy. The legislative history supports that interpretation. See Brief of Respondents, at 17. But the legislative history of this section, and of the comparability provision in 42 U.S.C. § 1396a (a) (17), indicates that there must be comparability between the medically needy and the categorically needy, as well as between the various categories of the medically needy. See Brief for Petitioner, at 18-20. Defendants can offer no explanation as to why their limiting interpretation of this part of the provision is required by the statute or its legislative history. In light of the numerous cases to the contrary, see Brief of Petitioner, at 26 n.19, the consistent analysis of HHS on this point, *id.*, at 20-25, and the strong rationales favoring consistency of treatment between the categorically and medically needy, see *id.*, at 31-34, no basis

[1]These inconsistent positions cannot be treated as "alternative" analyses. California premises its argument as to the meaning of the "except for income and resources" clause on the assumption that there is a requirement of comparability between the categorically and medically needy. Without that assumption, there is no place for that clause in their analysis, for they are asserting that the "except for" language creates an exception to the general comparability requirement. If there is no general comparability requirement between the categorically and medically needy, as the state contends is the meaning of the second part of the provision, then there is no need for the "except for" clause in the first part. The state cannot have it both ways.

exists for this limitation of the meaning of the comparability requrements.[2]

Finally, defendants contend that if there is a comparability requirement for the categorically and medically needy, then California satisfies it. Citing the Ninth Circuit's holding on this point, 622 F.2d, at 1311 (J.A. 65), the state notes the many financial conditions of eligibility in California which are the same for the categorically and medically needy, and thereby concludes that the rules of the two are comparable — if not identical. Brief of Respondents, at 18.

This analysis is irrational. It results in an entire class of individuals being treated in exactly the opposite manner from individuals identically situated. Even if comparability does not require identical treatment, it cannot permit diametrically opposite treatment of categorically and medically needy individuals who have committed exactly the same act. To contend that "comparability" permits opposite treatment of two groups with identical needs is to turn that word on its head. See *infra,* at 5-6 n.3.

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[2]Even the Ninth Circuit did not conclude that there was no requirement of comparability between the categorically and medically needy. See 622 F.2d, at 1310-1311 (J.A. 64). The appellate court agreed with defendants that the "except for" clause in the provision did not require that the same financial conditions of eligibility be employed, *id.*, at 1310 (J.A. 64), but, unlike defendants, it did not draw the internally inconsistent conclusion that the second part of the provision does not require any comparability between the categorically and medically needy. See *id.*, at 1311 (J.A. 64-65). Instead, that court carved out an exception to the common interpretation of 42 U.S.C. §1396a (a) (10) (C) (i), concluding that comparability only required similarity, *id.*, at 1311 (J.A. 65). Thus, the general requirement of comparability between the medically and categorically needy was not disputed by the Ninth Circuit. No appellate court, therefore, and only one district court, which was overruled (*Fabula*), has ever concluded that the comparability provisions of the Medicaid statute were not applicable to the categorically and medically needy. *(continued)*

Moreover, the fact that other eligibility conditions for the two groups are the same does not excuse a condition which is decidedly different for one group than the other. Each eligibility standard must be looked at separately. Otherwise, states could establish extremely stringent rules in one area — such as the resource eligibility standard — and use that to exclude large numbers of the medically needy. That cannot have been Congress' intent.[3]

(footnote continued from proceeding page)

Moreover, New York and Maryland also do not contend that there is no requirement of comparability between the categorically and medically needy. Instead, they assert the Ninth Circuit's analysis, that comparability does not require identical standards. See Brief Amici Curiae, at 3, 5-6. California therefore stands alone in contending that 42 U.S.C. § §1396a (a) (10) (C) (i) and 1396a (a) (17) do not require comparability between the categorically and medically needy.

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[3]In their brief, New York and Maryland cite a decision of this Court for the broad proposition that comparable does not mean identical. Brief Amici Curiae, at 6. That case, *Wheeler v. Barrera,* 417 U.S. 402 (1974), is not dispositive in this situation. In *wheeler,* the word "comparable" did not appear in the statute at issue. *Id.*, at 415 n.11. That requirement was a creation of HEW, representing its effort to implement the congressional intent that children in nonpublic schools receive assistance similar to that provided in public schools. The statute sought to provide services comparable in quality and scope; children with similar, not identical, needs were to receive similar, not identical, services. *Id.*, at 421 n.15. This broad approach, however, still mandated that if one service could not be provided, "the solution is to employ an acceptable alternative form." *Id.*, at 419-420. A comparability requirement could not be satisfied by only partial provision of services: "A program which provides instruction and equipment to the public school children and the same equipment but no instruction to the private school children cannot, on its face, be comparable." *Id.*, at 424-425. In this case, eligibility, not services, is at issue. Eligibility either exists or does not; there is no middle ground. *wheeler* underscores that the existence of some similar rules for the medically and categorically needy does not meet a comparability requirement. See *supra,* at 5.

(continued)

In a vacuum, "comparability" may encompass standards which are not identical; it does not, however, allow a state to treat two groups with identical needs in a diametrically opposite fashion. If comparability could be interpreted that broadly, it would be a meaningless requirement. HHS has defined comparability in the context of this issue, and that definition has been regularly validated.

II.

CALIFORNIA CAN PROVIDE NO RATIONALE FOR SUBSTITUTING THE DETERMINATION OF THE FEDERAL AGENCY WITH ITS OWN

Defendants are essentially arguing that their interpretation of the federal statute is better than that of HHS. States are not permitted, however, to replace the analysis of the responsible agency with a policy which they prefer. This determination by HHS is a reasonable one in light of the statute and its history, the consideration of numerous courts, and the practical reasons why the medically and categorically needy should be treated no differently. See *infra*, at 15-18. The reasonability of this interpretation precludes a reviewing court from substituting its own preference. *Udall v. Tallman,* 380 U.S. 1, 4 (1965); *Caldwell v. Blum,* 621 F.2d 491, 497 (2d Cir. 1980), pet. for cert. pending No. 79-2034 (filed June 24, 1980); *Fabula v. Buck,* 598 F.2d 869, 873 (4th Cir. 1979).

(footnote continued from proceeding page)

Excusing transfers for one group, while using them to deny eligibility to another with identical needs, is no more comparable than the provision of services to one group with none to the other. In this instance, the responsible agency has determined that the statutory term "comparable" can only be met by identical treatment. Nothing in *Wheeler* suggests that that decision is improper in this context.

Defendants attempt to circumvent this well-established standard for review of agency determinations in a curious manner. First, they contend that "in the absence of judicial review, this court should not defer to HHS' interpretation. . . ." Brief of Respondents, at 20. Secondly, they argue that HHS has been inconsistent on this issue. *Id.*, at 21. Thirdly, they assert that the applicable regulation, 42 C.F.R. §435.401 (c), does not mean what HHS says that it means. *Id.*, at 26-29.[4]

First, there has been judicial review on this issue, both on the general question of comparability and on the specific question of transfer rules. As plaintiff has noted, comparability between the medically and categorically needy has been accepted by every court which has issued a final decision. HHS is not alone in its interpretation, and this is a significant factor in evaluating the propriety of that interpretation. *Blue Chip Stamps v. Manor Drug Stores,* 421 U.S. 723, 733 (1976); *Caldwell,* 621 F.2d, at 497. Indeed, there has been considerably more judicial evaluation of this issue than of most. Furthermore, on the specific issue of transfer rules in light of the comparability provisions, the Ninth

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[4]Like the Ninth Circuit, the state treats plaintiff's contentions regarding the regulation as a separate argument. See Brief of Respondents, at 26-29; 622 F.2d, at 1313-1314 (J.A. 69-70). Plaintiff has always contended that the regulation and its predecessors effectuate HHS; interpretation that there is comparability between the categorically and medically needy. The statute, the regulation, and the explicit HHS pronouncements on this issue must be read as an integrated whole.

Circuit stands alone among federal and state appellate courts in its determination.[5]

Secondly, California appears to contend that the announced HHS policy is unconvincing because it is inconsistent. Yet defendants do not point to a different HHS interpretation from previous years to support this purported inconsistency. There is none: HHS has repeatedly held that the comparability requirements in "SSI" states forbid them from employing transfer rules. Instead, the state argues that HHS' approval of California's state plan and "its failure to take any action against the plan" evidences this inconsistency. *Id.*, at 21.

The latter contention is simply inaccurate. HHS has moved against the state through its usual method of initiating informal compliance hearings; this began with the letter of September 28, 1978 from the Regional Director setting out explicitly why the transfer rule was invalid. This approach is standard HHS operating procedure. See Brief for Petitioner, at 24 n.18. The attempt to resolve the problem by informal discussion, 45 C.F.R. §201.6 (c), is the common method of correcting improper state rules without resorting to the drastic remedy of terminating federal payments. See 42 U.S.C. §1396c.

Use of this procedure does not imply that the federal agency concurs with the state rule. If that interpretation of the Ninth Circuit were upheld, see 622 F.2d, at 1311 (J.A. 66), then HHS would be compelled to hold formal com-

[5]Defendants attempt to denigrate HHS' position by terming it a "letter interpretation". Brief of Respondents, at 20. But they ignore the numerous other expressions of HHS' analysis, and also the significance of that interpretation. The HHS Regional offices are following the announced and publicized policy of HHS. See Brief for Petitioner, at 22-23. They are not acting independently, nor have they invented their own position on this issue.

pliance hearings in every instance of an alleged non-compliance. The result would be a significant expenditure of resources to hold the hearings, and the regular termination of matching funds to states. The present procedure effectuates the goal of the statute without forcing either party into an extreme position at the outset.

Nor has HHS otherwise approved of the transfer rule, implicitly or explicitly. It does not even appear in the state plan filed with HHS.[6] Even if there were a reference to the rule in the plan, HHS' approval of the plan as a whole does not represent acceptance of every specific aspect of the plan — especially when the agency explicitly informs the state of its non-compliance on that point. *Fabula v. Buck, supra,* 398 F.2d, at 873 n.11; *Aitchison v. Berger,* 404 F.Supp. 1137, 1148 (S.D.N.Y. 1975), aff'd without opinion 538 F.2d 307 (2d Cir.), *cert. denied* 429 U.S. 890 (1976); *Winter v. Trainor,* CCH Medicare & Medicaid Guide, ¶28,151, at 10,999 (N.D.Ill. 1977); *Smith v. Vowell,* 379 F.Supp. 139, 161 (W.D.Tex.), aff'd without opinion 504 F.2d 759 (5th Cir. 1974). As the Fourth Circuit observed in reflecting on the minimal relevance of HHS approval of a state plan to the propriety of a specific eligibility rule: "[Its] slight persuasiveness becomes even more ethereal in the face of the agency's clear statements to the contrary." *Fabula,* 598 F.2d, at 873 n.11. The logical endpoint of California's analysis would be that a claimant could never effectively challenge a state rule, for, by definition, all rules would have been implicitly accepted by HHS as proper. *Accord Rosado v. Wyman,* 397 U.S. 397, 405, 406 & n.8 (1970).

[6] "The approved [California] State Medicaid plan does not contain any reference to the 'transfer of assets' prohibition which the State has imposed upon the 'medically needy.' " Amicus Brief of HHS, at 11, lodged with Ninth Circuit, in Support of Petitioner's Request for Rehearing *En Banc.*

In short, HHS' position on transfer rules has been consistent, both in California and throughout the country.[7] The state attempts, though, to further discredit reliance on HHS' analysis of the transfer rule in an unprecedented manner. It claims that the regulation does not mean what HHS states that it means. While the deference due a federal agency in interpreting a statute is considerable, an even greater deference exists when the agency is interpreting its own regulation. *United States v. Larionoff,* 431 U.S. 864, 872 (1977).

The essence of their argument is that the location of 42 C.F.R. §435.401 (c) in the regulations precludes it from applying to financial conditions of eligibility. Brief of Respondents, at 26-28. But HHS and its predecessor have always agreed that the regulations, in various wordings, codifications, and locations, correctly implemented the comparability requirement by precluding all more restrictive treatment of the medically needy. The parties agree that no substantive changes were made in the regulations during the recodification in 1978. Brief for Petitioner, at 21 n.15; Brief of Respondents, at 28. HHS and HEW have always

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[7]Defendants' reliance on *Michael Reese Physiucians and Surgeons, S.C. v. Quern,* 606 F.2d 732 (7th Cir. 1979), *cert. denied,* ____ U.S. ____ , 49 U.S.L.W. 3493 (1981), is unfounded. In that case, which involved Medicaid fraud and abuse, the court specifically noted that HHS had "declin[ed] thus far to take any action against the modification in the plan. . . ." 606 F.2d, at 735. Here, by contrast, there was no change in the plan, or even an explicit statement of the transfer rule. And, as has been noted, HHS *has* taken action.

interpreted their own regulations to require the same treatment.[8]

HHS has promulgated numerous regulations through the years which require comparability between the medically and categorically needy, culminating in 42 C.F.R. §435.401 (c). The agency has itself stated in various private and public communications that the two groups must have the same eligibility conditions, financial and otherwise.[9] There exists no basis for the Ninth Circuit's conclusion that HHS actually meant other than what it has explicitly and repeatedly stated.

III.

42 U.S.C. §1396a (a) (17) (B) REQUIRES CONSIDERATION OF ONLY AVAILABLE RESOURCES, AND MAKES NO EXCEPTION FOR RESOURCES PREVIOUSLY OWNED

This case is concerned only with resources which have been validly transferred, not with those still legally in the

[8]See 42 C.F.R. §§435.840 (a), 435.841 (a), both of which require "SSI" states to use the more liberal of the SSI or AFDC rules for their resource standards. Even if 42 C.F.R. §435.401 (c) were not applicable, these requirements could stand alone to preclude states from applying more restrictive resource rules, including transfer of assets provisions. But section 435.401 (c) is explicit and controlling, stating specifically that states "must not use requirements for determining eligibility for optional coverage groups that are — . . . (2) For aged, blind, and disabled individuals, more restrictive than those under SSI . . . ."

[9]*E.g.*: "[A]ll aged, blind and disabled persons . . . must have their eligibility determined using all SSI eligibility rules except for — and only except for — higher dollar amounts for income and resources eligibility." 42 Fed.Reg. 2685 (1977).

possession of the purported transferor. The importance of this distinction is reflected by the careful language in the SSI Claims Manual, §12507 (a), which proscribes different treatment for resources actually transferred from those which are not validly transferred. See App. D to Petition for Certiorari, at 37. Thus, by definition, the class members who see eligibility no longer have any legal right to the property which the state is attributing to them. The Medicaid statute, however, permits states only to consider income and resources which are "available" to the applicant. 42 U.S.C. §1396a (a) (17) (B).

Defendants counter that this provision of the statute also permits inclusion of resources which were *previously* in the possession of the claimant. There is no basis in the Medicaid statute now in effect for this claim.[10] While the cases cited by California, at 22-25, support this reliance on past ownership, they are premised on unsubstantiated assumptions as to what Congress intended with the "availability" requirement, rather than on what Congress actually wrote. There is no suggestion in the statute or its legislative history that Congress intended available resources to include property which was no longer in the possession of the applicant — regardless of the circumstances in which it was disposed of. As this Court recently stated: "The language of the statute is clear, and we have historically assumed that Congress intended what it enacted." *U.S. Railroad Retirement Board v. Fritz*, — U.S. —, 101 S.Ct. 453, 461 (1980).

The legislative history of the section underscores that "availability" must be strictly construed: "States [are] to take into account only such income and resources as . . . are

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[10]Compare Pub.L. 96-611, §5, 94 Stat. 3567 (1980), discussed *infra*, at 14.

actually available to the applicant or recipient. . . ." S.Rep. No. 404, 89th Cong., 1st Sess., 78, reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2018 (emphasis supplied). Obviously, if the claimant has legally divested herself of the property, it is no longer actually available.[11]

This Court has agreed with this interpretation in the identical context. In summarily affirming a district court decision invalidating Connecticut's transfer of assets rule for Medicaid and AFDC applicants, the Court implicitly accepted this analysis: "[B]y denying eligibility for assistance over a period of time during which a transferred asset would otherwise sustain the applicant, were it still available, the rule assumes the availability of unavailable resources, in clear contradiction of the case law doctrine." *Buckner v. Maher,* 424 F.Supp. 366, 373 (D.Conn. 1976), aff'd mem. 434 U.S. 898 (1977); see also *Woodard v. St. Clair,* CCH Medicare & Medicaid Guide, ¶ 30,804, at 9478 (S.D.Miss. 1980); *Owens v. Roberts,* 377 F.Supp. 45 55 (M.D.Fla. 1974).[12]

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[11]HEW guidelines threw further light on the issue: "Available income and resources are income and resources which are 'in hand' or under the control of the individual, preferably looking to a period not in excess of three months ahead. . . ." Handbook of Public Assistance Administration, Supplement D, §D-4230 (4), (R., Tab 13, p. 70).

[12]In a long line of cases, this Court and others have utilized a strict interpretation for the Medicaid availability requirement and for the similar one in the AFDC statute. See, *e.g., Van Lare v. Hurley,* 421 U.S. 338 (1975); *Brown v. Stanton,* 617 F.2d 1224 (7th Cir. 1980), pet. for cert. pending No. 79-1690 (filed April 25, 1980). Defendants attempt to distinguish these cases as involving a separate issue, Brief of Respondents, at 23 n.12, but all stand for the proposition that availability is to be strictly construed. In those cases, it meant that income could not be presumed available from relatives; in this case, it means that resources cannot be presumed available which are no longer in the possession of the applicant.

Under the California rule, the state is in fact treating a divested asset as one that is available. The state does this by calculating the period of ineligibility based on the uncompensated value of the transferred asset. 22 Cal. Admin.C. §50411(a). But there is no present basis in the federal statute for this assumption of availability. By contrast, the new federal transfer rule specifically sets out an exception to the general rule of availability in the SSI and Medicaid programs for the purpose of determining the period of ineligibility. See Pub.L. 96-611, §5(a), (b), 94 Stat. 3567, 3568 (1980).

Defendants have thus made an impassioned argument that Congress could not have intended the availability requirement not to include assets recently transferred. They base this analysis on the policy which they prefer, not on the statute itself. Similarly, the Wisconsin Supreme Court could find no basis for its decision upholding that state's transfer rule beyond an unsubstantiated belief that a prohibition against transfer rules "could not have been contemplated by [Congress] when it enacted Title XIX, nor by HEW when it promulgated regulations thereunder." *Lerner v. Division of Family Services,* 235 N.W.2d 478, 484, 70 Wis.2d 670 (1975). But until Congress did specifically carve out an exception to the requirement of present and actual availability in Pub.L. No. 96-611, there were and are no grounds for this conclusion. While the Wisconsin Supreme Court

and the Ninth Circuit may prefer that states count resources no longer in the possession of the claimant, there is no statutory authority for that action.[13]

IV.

CONGRESS AND HHS HAVE RECOGNIZED THAT COMMON SENSE REQUIRES IDENTICAL TREATMENT OF THE MEDICALLY AND CATEGORICALLY NEEDY

California, Maryland, and New York argue throughout ther briefs that logic supports the differential treatment of the medically and categorically needy. The only distinction between the two groups, however, is the greater gross income of the medically needy. Congress had determined that that difference is of no significance since members of both groups are unable to afford medical care. It is for that reason that the same rules should be applicable to individuals in both groups.

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[13]Reliance on the rules permitting states to count income and assets to be obtained up to six months in the future, see 622 F.2d, at 1313 (J.A. 68); Brief of Respondents, at 25-26, is entirely misplaced. Those provisions are for administrative convenience, so that states need not make an eligibility determination every month. And those regulations derive directly — and with no substantive changes, see 43 Fed.Reg. 45176 (1978) — from regulations which specified that the state plan must "provide that only such income and resources will be considered as will be 'in hand' within" the future period. 42 C.F.R. §448.4 (c) (4) (1977). The "in hand" requirement significantly differentiates that rule from the suggestion that a resource which, by definition, is not "in hand" can still be counted. Moreover, another regulation, to which defendants allude, but do not discuss, Brief of Respondents at 25, specifies that a state "must — . . . consider *only* resources available during the period for which income is computed under §435.831 (a)." 42 C.F.R. §435.845 (b) (emphasis supplied). The regulations thus specifically preclude a state from considering past resources available.

Were it otherwise, the same people would have different rules applied to them for the same act depending on whether they were considered medically or categorically needy. Brief for Petitioner, at 32-33 & n.24. And, similarly, the spouse who was not responsible for an uncompensated transfer would have eligibility denied because he is medically needy, while the spouse who actually transferred remains untouchable because she is categorically needy. See *Robinson v. Pratt,* 497 F.Supp. 116, 117-118. (D.Mass. 1980), appeal pending No. 80-1750 (1st Cir.). It is to avoid these illogical and unjust results for people who are in the same economic position that Congress determined that the same rules be applied to them. And the courts have repeatedly recognized this logic. See *e.g., Fabula v. Buck, supra,* 598 F.2d, at 874.

The states respond in part, however, that it is logical to apply a different rule to SSI recipients than to the medically needy, as the amount at stake in SSI benefits is sufficiently small that, they contend, a prohibition against transfers would serve no purpose. Brief of Respondents, 38-39; Brief of Amici, at 6-7. This contention is both irrelevant and wrong. First, it is solely a policy argument; the federal statute and the regulations simply do not permit this differential treatment. In any event, it is factually inaccurate. The states ignore that Medicaid eligibility flows directly from SSI eligibility; consequently, the same benefits are at stake for both cash assistance recipients and those with incomes over those levels: Medicaid. Congress and HHS have thus rationally concluded that with the same benefits at issue, states should not be permitted to treat one group in a different manner than the other.

Indeed, Congress has reiterated this approach in its recent transfer legislation. As California notes, at 43, the new

federal law establishes a basis for denying eligibility to *both* the categorically needy (for SSI benefits and for Medicaid) and to the medically needy. While thus changing its policy regarding transfer rules, Congress has not changed its overall approach that the medically needy should not be treated differently than the categorically needy. Senator Long noted that individuals were transferring in order to obtain eligibility under both programs, so that a rule prohibiting this policy was necessary in each. 126 Cong.Rec. S.16505 (daily ed., Dec. 13, 1980).[14]

Defendants repeatedly assert that California's transfer rule is necessary to prevent fraudulent practices and to save finite resources for those "truly" in need. They admit, though, that the new transfer rule severely undercuts their claims of overwhelming expenses. Brief of Respondents, at 7 n.7. But they ignore a significant contradiction to their claim that the transfer rule prevents fraud. California's rule is applicable to *all* transferred resources, regardless of whether those resources are exempted in determining Medicaid eligibility. The plaintiff's residence, for instance, was exempt at the time of the transfer, and remains so, since Mr. Beltran still lives there. 22 Cal.Admin.C. §50425 (a) (4); SSI Claims Manual § 12570 (b). Thus, had it not been given to the children, it would not have been counted as a resource, and its value could not have been counted in determining Antonia Beltran's eligibility. It is difficult to imagine how the transfer of an exempt resource could be intended to obtain

[14]Sen. Long also repeated the Congressional recognition that a federal transfer rule was needed because "the present law is so written" as to permit applicants to transfer. 126 Cong.Rec. S.16505.

Medicaid eligibility — since its retention could not affect eligibility.[15]

The state is thus on weak ground when it offers the equitable argument that transfer rules like California's are a necessity to prevent wholesale fraudulent actions. Many, perhaps most, applicants against whom the transfer rule is applied are elderly individuals who give away exempt residences, often to their children. Transferring an exempt resource should not be considered a fraudulent act, yet California does not discriminate between exempt and non-exempt resources in the application of its rule. The new federal legislation, however, specifically recognizes the illogic of this practice. It excludes exempt resources from those which can be considered available when the transfer prohibition is applied: "In determining the resources of an individual . . . there shall be included (*but subject to the exclusions under subsection (a)*) [of section 1613 of the Social Security Act] . . . ." Subsection 1613 (c) (1) of the Social Security Act, as added by Pub.L. No. 96-611, § 5(a), *supra* (emphasis supplied). Subsection 1613 (a) of the Act, 42 U.S.C. § 1382b (a), sets out the resources excluded from consideration in determining SSI eligibility. Among them, of course, is the applicant's home. 42 U.S.C. § 1382b (a) (1).

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[15]The state cannot claim that divestment of an exempt asset is still a permissible reason to deny eligibility on the grounds that the transfer precludes the state from recovering some of the cost of medical care after the death of the recipient. See 42 U.S.C. § 1396a (a) (18); *Fabula v. Buck,* 598 F.2d, at 871. Despite the Ninth Circuit's contention, 622 F.2d, at 1308 (J.A. 60), California has no state statute permitting such a recovery. Brief of Respondents, at 4 n.4. Thus, a transfer could not be intended to avoid state action after the applicant's death because the state cannot take that action.

The state's arguments essentially reduce to a contention that its procedures are proper because it seeks to weed out those who do not truly need assistance; to support this argument, defendants are forced to contend that HHS not only misinterpreted the Medicaid statute, but its own regulations as well. California is unable, however, to present any legal reason why its preference, rooted in its evaluation of policy concerns, should prevail over that of the responsible agency. There is, at the least, strong support in the statute, its legislative history, and the agency's consistent efforts, for the HHS conclusion that states may not apply transfer rules to the medically needy. This interpretation is "reasonable and consistent with the statute, and [is] entitled to be followed by the courts." *Fabula,* 598 F.2d, at 873 (footnote and citation omitted); see also *Caldwell,* 621 F.2d, at 497. The Ninth Circuit's effort to avoid this necessary result supplants logical and reasonable interpretations with an unsupportable analysis of the statute and HHS' own regulations. At best, it is a less logical and supportable interpretation than that of HHS; moreover, it contravenes the numerous other courts which have analyzed the issue.

This Court has often stated that " 'the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong. . . .' " *New York State Dept. of Social Services v. Dublino,* 413 U.S. 405, 421 (1973), quoting *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381 (1969). With this substantial presumption favoring the determination of the responsible agency, there is simply no basis for the Ninth Circuit's determination. California's transfer of assets rule is impermissible under federal law.

CONCLUSION

The decision of the Court of Appeals should be reversed.

DATED: March, 1981.

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No. 80-5303

IN THE

Supreme Court of the United

October Term, 1980

ANIA BELTRAN, individually and on behalf of all others similarly situated,

Petitioner,

-against-

BEVERLEE A. MYERS, individually and as Director, California State Department of Health; and ELISABETH LYMAN, individually and as Deputy Director, California State Department of Health,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE ATTORNEYS GENERAL OF THE STATE OF NEW YORK AND THE STATE OF MARYLAND, *AMICI CURIAE*, IN SUPPORT OF THE JUDGMENT APPEALED FROM

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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE ATTORNEYS GENERAL OF THE STATE OF NEW YORK AND THE STATE OF MARYLAND, *AMICI CURIAE*, IN SUPPORT OF THE JUDGMENT APPEALED FROM

Interest of the State of New York

New York supports the right of a state participating in the Medical Assistance Program authorized under Title XIX of the Social Security Act (42 USC § 1396, *et seq.*) to impose a transfer-of-assets prohibition which has the effect of requiring persons to apply their own assets to their medical expenses rather than giving them away to relatives and friends for the purpose of qualifying themselves for medical care and services at public expense. It is

axiomatic that a state has only finite resources available for the care and support of its indigent citizens. In the absence of an expression of congressional intent to the contrary, and consistent with the purpose of the Medical Assistance Program to enable each state "* * * as far as practicable under the conditions in such State, to furnish * * * medical assistance on behalf of * * * individuals, whose income and resources are insufficient to meet the costs of necessary medical services * * *" (42 USC § 1396), we argue for the proposition that each state has had since the inception of the program the right to conserve its limited resources by restricting medical assistance to those who are truly needy, and denying it to those who have created their own need by giving their assets away for the purpose of qualifying. This existing right was recognized by Congress in December, 1980 when it passed H.R. 8406 which was signed into law by the President on December 28, 1980 (designated as Public Law 96-611). It specifically authorizes states to impose broad transfer-of-assets prohibitions in the Medical Assistance Program.* We believe that the Court below correctly held that California's transfer-of-assets prohibition as applied before the change in Federal law did not conflict with the provisions of 42 USC § 1396a (a) (10) (C) and 1396a (a) (17) (*Dawson v Myers*, 622 F2d 1304 [9th Cir, 1980]).**

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*P.L. 96-611 also imposes a transfer-of-assets prohibition in the Federal Supplemental Security Income (SSI) program (42 USC § 1381, *et seq.*).

**Although New York is no longer an "SSI" state like California, and has become a "209(b)" state (see petitioner's brief, p 33), we believe the decision of the Court below is of significant importance for all states participating in the Title XIX program. New York still has pending before this Court a petition for certiorari in the matter of *Blum v Caldwell, et al.*, (petition filed June 24, 1980, Docket No. 79-2034) which raises an issue similar to that presented in the case at bar.

ARGUMENT

The Court below correctly held that the imposition by California of its transfer-of-assets prohibition on medically needy aged, blind and disabled applicants for and recipients of medical assistance did not conflict with the requirements of Title XIX.

A.

State transfer-of-assets prohibitions in the Medical Assistance Program establish complementary eligibility standards which are consistent with the purpose of the Title XIX Medical Assistance Program (42 USC § 1396). This Court has held that state collateral eligibility standards in public assistance programs should not be voided by the Courts unless there is a clear manifestation of congressional intent that such requirements may not be imposed (*New York State Dept. of Social Services v Dublino*, 413 US 405, 413 [1973]).

Title XIX contains no provision which precludes state transfer-of-assets prohibitions. Apparently such prohibitions were not seriously questioned until after the Federal Supplemental Security Income (SSI) Program (42 USC, § 1381, *et seq.*) became effective in 1974, when the comparability issue under 42 USC, § 1396a (a) (10) (C) and § 1396a (a) (17) was raised in cases such as the one at bar (see for example, *Fabula v Buck*, 598 F2d 869 [4th Cir, 1979]; *Caldwell v Blum*, 621 F2d 491 [2d Cir, 1980]; also, Senate Report No. 471, 96th Congress, 1st Sess. pp 48-49 [1979]; *Lerner v Division of Family Services*, 70 Wis 2d 670 [1975], 235 NW2d 478; *Drogolewicz v Quern*, 74 Ill App 3d 862 [1979], 393 NE2d 1212). However, comparability does not require identical treatment between the "medically needy" and the "categorically needy" (see Subpoint "B" *infra*), and there is no clear manifestation of Congressional intent that Congress intended to prohibit transfer-of-assets prohibitions by enacting comparability requirements (*Caldwell v Blum, supra*, 621 F2d at 495).

Congress apparently intended in 1965 that the purpose of comparability under the medical assistance program (42 USC, § 1396a [a] [10]) was to:

> "make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them." S. Rep. No. 404, 89th Cong., 1st Sess. 77-78 (1965); see H. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965).

When in 1973 Title XIX was amended to extend medical assistance coverage to SSI recipients, and optional coverage to categorically-related persons, only technical amendments were made to the comparability provision contained in 42 USC § 1396a (a) (10) with respect to extending coverage to "all individuals who would, except for income and resources, be eligible * * * to have paid with respect to them supplemental security income benefits * * *" (P.L. 93-233, § 13). This amendment was then described as treating the matter of Medicaid eligibility for SSI recipients (Cong. Record - Senate, Dec. 21, 1973, p 43100), and was characterized by Senator Mondale as having the purpose of preserving "* * * medicaid eligibility for the aged, blind and disabled" (Cong. Record

- Senate, Dec. 21, 1973, p 43113). This is inconclusive on the issue at bar.

Thus Congress had not manifested any intention to prevent states from enacting transfer-of-assets prohibitions either when the Medical Assistance Program was first enacted into law, or when its provisions were later amended with respect to the SSI program.* Accordingly, we urge that state transfer-of-assets prohibitions applicable only to the "medically needy" did not conflict with Title XIX in the absence of a clear expression of congressional intent that they were impermissible (cf. *Lerner v Division of Family Services, supra*, 393 NE2d at 484-485).

B.

The interpretation of the Department of Health and Human Services that the comparability provisions of Title XIX prevented "SSI" states from imposing transfer-of-assets prohibitions on the "medically needy" because they could not be imposed on the "categorically needy" is lacking in rationality, and unauthorized by Title XIX (see subpoint "A", *supra*). Therefore, the Court below properly refused to defer to the agency's interpretation (*Red Lion Broadcasting Co. v F.C.C.*, 395 US 367, 381 [1969]; *Shea v Vialpando*, 416 US 251, 262, n. 11 [1974]; *New York State Department of Social Services v Dublino, supra*).

As held by the Court below, the comparability provision of 42 USC § 1396a (a) (10) (C) (i), which pertains to income and resources, does not require that "indentical" standards must be

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*The Court below properly rejected subsequent legislative history, which apparently relied upon erroneous interpretations of Federal law by the Department of Health and Human Services (HHS) (previously the Department of Health, Education and Welfare) (*Dawson v Myers, supra*, 622 F2d at 1311).

applied to the "categorically needy" and the "medically needy", since:

> "[c]omparable only means that there must be enough similar characteristics or qualities to make comparison appropriate. Webster's Third New International Dictionary, G. & C. Merriam Co. (1976). The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the *medically needy* group (including the transfer rule) are not comparable to those which are used under the SSI program". (*Dawson v Myers, supra*, 622 F2d at 1311)

This court has also held that "'[c]omparable' * * * does not mean 'identical' * * *" (*Wheeler v Barbera*, 417 US 402, 420 [1974], mod 422 US 1004 [1975]). Comparability can exist when there are "some differences" between the subjects being compared (*Zuniga v Amfac Foods, Inc.*, 580 F2d 380, 386 [10th Cir, 1978]).

A tranfer-of-assets prohibition does not have the same significance for the SSI program as it does for the medical assistance program. There is no logical correlation between the transfer of property for the purpose of qualifying for SSI, and the transfer of property for the purpose of qualifying for medical assistance. It is unlikely that an applicant for SSI would transfer vast assets to qualify for a small fixed Federal monthly income benefit (42 USC §§ 1382 [b], 1382f), as supplemented by the State in which he resides (42 USC § 1382e). Comparable considerations, however, do not apply to applicants for medical assistance since these benefits are unlimited. For instance, a person who is entering a nursing home to spend the remainder of his or her life, where the cost of care and treatment is many thousands of dollars every year, has a tremendous incentive to transfer considerable assets to family or friends rather than use them to pay the cost of medical care. Thus,

the HHS interpretation that comparability requires indentical treatment in this respect between the "medically needy" and "categorically needy" is irrational.

Moreover, the HHS interpretation irrationally defeats the purpose of the spend down provision contained in Title XIX (42 USC § 1396a [a] [17]). Under such provision an applicant for or recipient of medical assistance is required to apply his excess income toward the cost of his own medical costs (S. Rep. No. 404, 89th Cong., 1st Sess. [1965], US Code Cong. & Admin. News, 1965, p 2019). By interpreting the comparability provisions to require identical treatment between SSI "medically needy" and "categorically needy", applicants for and recipients of medical assistance are left free to give their property away rather than spend down as intended by Congress.

Admittedly, HHS has achieved programmatic symmetry by requiring identical treatment between the SSI "medically needy" and "categorically needy". However, such interpretation does not rationally further the purposes of the medical assistance program, and it is unauthorized by Title XIX. The Court below properly rejected it, and upheld the California transfer-of-assets prohibition.

CONCLUSION

The Judgment of the Court of Appeals should be affirmed.

Dated: Albany, New York
January 16, 1981

Respectfully submitted,

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